



## **University of Huddersfield Repository**

Brammer, Andrew

A case study of the factors and processes involved in the use of compulsory powers when carrying out Mental Health Act 1983 (amended 2007) community assessments, from the perspectives of Approved Mental Health Professionals in one local authority in the North of England – A Critical Realist Perspective

### **Original Citation**

Brammer, Andrew (2020) A case study of the factors and processes involved in the use of compulsory powers when carrying out Mental Health Act 1983 (amended 2007) community assessments, from the perspectives of Approved Mental Health Professionals in one local authority in the North of England – A Critical Realist Perspective. Doctoral thesis, University of Huddersfield.

This version is available at <https://eprints.hud.ac.uk/id/eprint/35312/>

The University Repository is a digital collection of the research output of the University, available on Open Access. Copyright and Moral Rights for the items on this site are retained by the individual author and/or other copyright owners. Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided:

- The authors, title and full bibliographic details is credited in any copy;
- A hyperlink and/or URL is included for the original metadata page; and
- The content is not changed in any way.

For more information, including our policy and submission procedure, please contact the Repository Team at: [E.mailbox@hud.ac.uk](mailto:E.mailbox@hud.ac.uk).

<http://eprints.hud.ac.uk/>

**A case study of the factors and processes involved in the use of compulsory powers when carrying out Mental Health Act 1983 (amended 2007) community assessments, from the perspectives of Approved Mental Health Professionals in one local authority in the North of England – A Critical Realist Perspective**

Andrew Brammer

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Philosophy

October 2020

## **Contents**

ABSTRACT	6
ABBREVIATIONS	7
KEY TERMS AND CONCEPTS	8
1. INTRODUCTION	9
2. LITERATURE REVIEW	13
2.1 Introduction	13
2.2 Key terms	13
2.3 Towards an understanding of mental illness	15
2.4 Diagnosis and the DSM	20
2.5 Neo Marxian and Critical Realist Approaches	24
2.6 Risk and Dangerousness	28
2.7 Assessment and Decision-making	31
2.8 Weighing and Balancing Decisions	35
2.9 Decision making by Approved Social Workers	41
2.10 Professional Roles and the AMHP	45
2.11 Risk and Mental Health Assessment	52
2.12 Considering Social Context and Alternatives to Detention	56
2.13 Mental Disorder and Social Work Decision-making: the Synergies and Differences between the Mental Capacity Act 2005 and the Mental Health Act 1983 (Amended 2007)	60
2.14 Individual Perspectives and Organisational Pressures	65
2.15 Chapter Summary and Research Aims	67
3. METHODOLOGY	71
3.1 Design	71
3.2 Ontology, Epistemology and Methodology	72
3.3 Critical Realism	74
3.4 The Case Study Approach	77
3.4.1 Context of the Case study	79
3.5 Methods	82
3.5.1 Design and Rationale	82
3.5.2 In-depth Interviews	82
3.5.3 Vignettes	84
3.5.3.1 Vignette and Introduction	86
3.5.4 Focus Group	91

3.6 Participants	95
3.6.1 Interview Participants' Profiles	95
3.6.2 Focus Group Participants' Profiles	98
3.7 Insider Research and Reflexivity	99
3.8 Ethical Considerations	102
3.9 Data Analysis	103
3.9.1 Stage One	104
3.9.2 Thematic Grid	106
3.9.3 Stage Two	107
3.9.4 Risk Grid/Risks Explored in a MHA Assessment	108
3.9.5 Conflicts Grid/Conflicts experienced in a MHA Assessment	110
3.9.6 Expectations Grid/ Expectations expressed about a MHA Assessment Outcome	110
3.9.7 Stage Three	111
3.10 Focus Group Analysis	111
3.11 Summary	113
4. INTERVIEW FINDINGS	114
4.1 Introduction	114
4.2 The Legal Framework	115
4.3 Frameworks of Consideration	120
4.3.1 Considering the Criteria	121
4.3.2 Criteria: Nature or Degree	121
4.3.3 Health, Safety & Protection of Others	122
4.3.4 Current Concerns	124
4.3.5 Complex Decision-making	127
4.4 Defining Risk	133
4.4.1 Calculating Risk	137
4.4.2 Clinical History as a Risk Indicator	141
4.5 Roles and Accountability	145
4.6 Capacity, Insight and Understanding	152
4.7 Social Factors	158
4.8 Conclusions	163
5. FOCUS GROUP FINDINGS	164
5.1. Legal Safeguard	165
5.2 Views of Mental Illness	168

5.3 Social Causation	177
5.4 Resource-led Admissions	181
5.5 Patient-driven Admissions	185
5.6 Conclusions	193
6.DISCUSSION	195
6.1 Introduction	195
6.1.2 Contribution to Knowledge	197
6.3 AMHPs use of Frameworks of Understanding	197
6.4 Considering Mental Illness and Mental Disorder	199
6.5 Social Perspectives Framework	205
6.6 Risk Framework	208
6.6.1 Deconstructing Risk	212
6.7 Legal Framework	216
6.7.1 Considering Less Restrictive Alternatives	217
6.7.2 Capacity and Insight; Medical meets Legal	219
6.8 The Identity and Role of the AMHP	223
6.8.1 Inter-professional Frameworks	223
6.8.2 Alienation and the AMHP Role	226
6.9 Conclusions	233
7. REFLECTIONS	238
7.1 Reflections on Methodology	238
7.2 Reflexivity: Insider Research	241
7.3 Contribution to Knowledge	243
8 APPENDICES	247
8.1 Conference Presentations	247
8.2 Transcript Examples	248
Participant J1	248
Participant H1	252
Participant G1	260
8.3 Coding	266
8.4 Thematic Grid	268
8.5 Evidence Grids	275
8.5.1 Risk Grid/Risks Explored in a MHA	275
8.5.2 Conflicts Grid/Conflicts Experienced in a MHA	288

8.5.3 Expectations Grid/ Expectations Expressed about a MHA Assessment Outcome	293
8.6 Research Invitation	297
8.7 Information Sheet Interviews	298
8.8 Information Sheet Focus group	300
8.9 Consent	302
8.10 Permission	304
8.11 Ethical approval	305
9. REFERENCES	306

## ABSTRACT

In England and Wales, the Mental Health Act 1983 (amended 2007) is the primary piece of legislation for the assessment, treatment, and detention of those deemed to be mentally disordered. The task of considering and coordinating assessments and making the application for detention rests with the Approved Mental Health Professional (AMHP).

The aim of this research was to explore the various factors that impact upon and influence the decision-making of AMHPs. The research was a qualitative exploration of the decision-making of AMHPs using semi structured interviews followed up with a focus group. 18 Semi-structured interviews with AMHPs were undertaken using a fictitious vignette of a community-based assessment. The focus group with seven AMHPs further explored their beliefs about the purpose of mental health legislation.

The study found that AMHPs applied their own frameworks of understanding to the process of assessment which incorporated a range of variables that they recognised as risk indicators. Risk was the primary reason for undertaking Mental Health Act 1983 (amended 2007) assessments and the primary consideration with regards to detention in a psychiatric hospital. The assessment of risk closely reflected the principles of the Act and criteria under the legislation regarding the person's health, safety or with a view to the protection of others. The focus group revealed how the AMHPs identify as a distinct professional group who have a critical view of the legislation and medical approaches to mental illness. The medicalisation of mental distress, lack of viable alternatives to in-patient admission and the risk/blame culture were identified as negative factors that could lead to the decision to detain. This included conflicts about particular groups of service users who were perceived to be driving their own admission or detention in opposition to the view of the AMHP.

The conclusion of the research is that the decision making of AMHPs is multi-factorial and involves situational interpretation using individual frameworks which incorporate professional values, practice wisdom and pragmatism. The AMHP can therefore be said to function as a critical realist in that he/she is crafting contemporary mental health practice through a reflective lens coloured through the constructivist concepts of discourse, language and identity and, which is grounded in social realities. The AMHP strongly values his/her right to make independent decisions, a role that is paradoxically enshrined within the legislation and also limited by it.

## **TITLE**

**A case study of the factors and processes involved in the use of compulsory powers when carrying out Mental Health Act 1983 (amended 2007) community assessments, from the perspectives of Approved Mental Health Professionals in one local authority in the North of England – A Critical Realist Perspective**

## **ABBREVIATIONS**

AMHP – Approved Mental Health Professional

APA – American Psychiatric Association

ASW – Approved Social Worker

BIA – Best Interest Assessor

BME – Black & Minority Ethnic

CoP/MCA – Code of Practice Mental Capacity Act 2005

CoP/MHA – Code of Practice Mental Health Act 1983 (Amended 2007)

CQC – Care Quality Commission

CRPD – Convention on the Rights of Persons with Disabilities

DH – Department of Health and Social Care

DoLS – Deprivation of Liberties Safeguards

DSM – Diagnostic Statistical Manual

HBT- Home Based Treatment

HRA – Human Rights Act 1998

ICD – International Classification of Disease

MCA – Mental Capacity Act 2005

MHA – Mental Health Act 1983 (Amended 2007)

MHAA – Mental Health Act Assessment

## KEY TERMS AND CONCEPTS

**Consideration** - The term consideration is used throughout to describe the legal responsibility of the AMHP to consider formal requests for assessment under the MHA.

**Mental disorder** – The term mental disorder will primarily be used in the legal context of mental health legislation and the requirement that suitably qualified practitioners identify the presence of a mental disorder as defined by section 1 (2) MHA.

**Mental illness** – This is used as a generic term to refer to the experience of mental distress, altered perception or perceived abnormal behaviours. I acknowledge that the language relating to this subject is highly contentious. Mental illness is used because it provides a familiar reference point for the reader.

**Service user**- This is used as a non-medical term to describe someone considered to be experiencing mental illness or someone already receiving mental health care.

**Patient** – This is used as a medical term when referring to service users subject to the compulsory powers of the MHA

## **1. INTRODUCTION**

Professionals working in the field of mental health and disorder, and who are involved in making decisions regarding a service user's mental state under the Mental Health Act 1983 (amended 2007) (MHA) are required to be approved by a local authority as an Approved Mental Health Professional (AMHP). The purpose of this thesis was to explore the key factors that affect or determine the decision-making of AMHPs, and the 'Frameworks of Understanding' drawn upon when undertaking such assessments. The role of the AMHP is part legal, part medical and part social work (Brown, 2013). It is predominantly undertaken by AMHPs from a social work background, although the 2007 amendment to the MHA opened the role to other mental health professionals. The role is intended to give an independent perspective on the assessment of a person's mental health that incorporates all the relevant factors, including the medical recommendations from doctors and the consideration of alternatives to admission (Brown, 2013).

### **1.1 Frameworks of Understanding used in the thesis**

The literature suggests (Strachan & Tallant, 1995; Russo & Shoemaker, 1992; O'Sullivan, 2011) that social workers and other professionals use frameworks of understanding to make sense of the situations or problems they are faced with. These frameworks of understanding are schemas that enable the professional to assimilate and manage their understanding of a given situation. They are constructed using rules, tacit knowledge and practice wisdom of a given profession. They are boundaried by their perceived role and applied in practice to construct a problem and develop a map that leads to possible solutions or desirable outcomes. The construction of these frameworks of understanding also contains elements of the professionals' own personal/ideological beliefs, personal experience, and practice experience. The decisions that AMHPs have to make are boundaried by a legal framework but the context of the actual assessment presents them with the challenge of considering each individual and situation as unique. The way in which all the factors interact in the option building of the decisional process and the way in which AMHPs interpret what appears to be static legislation when considering fluid social situations has been the task of this study.

The decisions of the AMHP require the application of a legal framework, within which relevant social and cultural factors are considered (DOH, 2015). The primary piece of legislation relating to the area of study is the MHA. In addition to this, where any disturbance of the mind or brain is present, AMHPs need to be cognisant of the Mental Capacity Act 2005 (MCA) in their daily practice and decision-

making. As part of the MHA amendment of 2007, the Deprivation of Liberties Safeguards (DoLS) were introduced (soon to be replaced by Liberty Protection Safeguards). These separate but closely related pieces of legislation are pertinent to the care, treatment and safeguarding of adults in England and Wales who have a mental disorder. Where compulsory detention under the MHA is being considered, this must be justified on the grounds of being in the interest of the person's health, safety, or for the protection of others. The decision to detain someone to prevent them from harming themselves raises the question of what level of autonomy a person can have regarding their own health, welfare or existence before the state intervenes (Allen, 2013). The AMHP as a public authority has an important role therefore, in safeguarding the rights of service users under Articles 2, 3, 5 and 8 of the Human Rights Act 1998 (HRA) and ensuring that any intervention that interferes with these rights is both necessary and proportionate. The AMHP has to consider Article 2 the right to life and Article 3 freedom from torture, inhumane and degrading treatment, at the same time they have to balance these rights with article 5 the right to liberty and security, and article 8, the right to respect for private and family life. The recent history of powers to detain or deprive people of their liberty are closely related, and the British legal system has endeavoured to bring itself in line with the European Convention on Human Rights (Jones, 2019). This alignment is given effect through the guiding principles of the MHA, as outlined in The Code of Practice (2015) (CoP/MHA) detailed below:

*1. Least restrictive option and maximising independence*

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

*2. Empowerment and involvement*

Patients should be fully involved in decisions about care, support, and treatment. The views of families, carers, and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

*3. Respect and dignity*

Patients, their families, and carers should be treated with respect and dignity and listened to by professionals.

*4. Purpose and effectiveness*

Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

#### *5. Efficiency and equity*

Providers, commissioners, and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe, and supportive discharge from detention.

(DOH, 2015 p. 22)

The reports by the Department of Health (DH) (2013) and the CQC (2014) posed questions as to why there were changing outcomes in relation to AMHP decision-making (including rising numbers of detentions) and invited further research into this process to start to fill the gap in our understanding. Further, the literature identifies that there are a range of factors that affect the decision-making of mental health professionals. These factors include legislation, legal guidelines, organisational procedures, situational factors, perceived risk factors, resource factors and individual differences of decision-makers. The reports from the DH (2013) and CQC (2014) show how the gathering and analysis of statistical data can enable researchers to identify trends and hypothesise about possible reasons for these, including the possibility of subjective or pragmatic decision-making being a causal factor in the variance of outcomes. However, as the authors conclude themselves, further research was required to confirm this. At the time that the CQC (2014) report was published, the prevailing view was that there were an increasing number of detentions in hospital rather than informal admissions, and that this was in part due to a shortage of inpatient psychiatric beds. However, a Supreme Court ruling (March 2014) relating to the deprivation of liberty for those who lack capacity directly impacted on the decision as to whether someone can be admitted to psychiatric hospital informally and is likely to be an additional factor influencing decision-making. Significantly for my study, the ruling highlights the fluid and constantly changing landscape of mental health practice and the need to critically analyse it.

The CQC (2018) report investigated some of the issues perceived to be contributing to rising detentions. Some of the increase was attributed to demographic changes, such as an increase in overall population, ageing population, increased numbers of those with dementia and closure of inpatient facilities meaning more people living in the community. The report also highlighted

legislative changes, such as the MHA amendment in 2007 that broadened the definition of mental disorder to include personality disorders, and the Cheshire West Ruling in 2014 that reduced the scope for informal admissions and increased the likelihood of formal detention. The use of criminal justice diversion focusing on treatment rather than prison was also considered to be a possible factor. The reduction in community alternatives to detention was also highlighted, as well as changes in social demographics such as increased substance misuse, homelessness and new immigrant populations who were unable to access mental health support. The report did assert that the use of detention to access scarce beds was not evident but, apart from this and the identification of the absence of alternatives to detention, there was very little in the report that focused on the subjective role of mental health practitioners including AMHPs. Examining how the AMHP relates to all these contextual factors whilst working within a statutory framework of the law is one of the aims of this study.

The thesis consists of eight chapters; chapter one provides context sets out the rationale for the study; chapter two and three comprise the literature review. This includes in chapter 2 the method that was adopted when reviewing the literature and background discussion relating to concepts of mental illness/disorder, chapter three focuses on literature relating to professional decision making. Chapter 4 covers the theoretical position taken in the consideration of methodology and the methods of inquiry that were developed. The research findings are presented in Chapters 5 and 6 and are separated into two chapters to reflect the two methods of enquiry that were adopted. The implications of the findings in relation to the literature are synthesised and discussed in chapter 7 and final conclusions are presented in chapter 8.

## **2. LITERATURE REVIEW**

### **2.1 Introduction**

A scoping review (Arksey & O'Malley, 2015) of the literature was carried out. This was not intended to be a comprehensive history of decision-making in mental health practice, but rather to present a critical synthesis (Kiteley & Stogden, 2014) of current developments. An electronic search was undertaken using the Summon service at the University of Huddersfield (searching Ethos; Google Scholar; Open Access Journals; Social Care Online; Summon). Other articles were identified by harvesting the references of the articles already selected. The websites of key organisations including the Critical Psychiatry Network were also searched to identify open source materials.

### **2.2 Key terms**

In the initial stages of the literature search, a more expansive range of terms were used. As this process progressed, the terms were narrowed to the following key terms: approved mental health professional; mental capacity; Mental Health Act; social work; decision-making; detention; admission; risk assessment; mental illness; mental disorder; psychiatry; critical psychiatry; anti psychiatry.

*Inclusion criteria* - both refereed peer reviewed journal articles and the grey literature were included (CQC, 2014; DOH, 2013). The grey literature sourced refers primarily to government reports on detention and admission and legal rulings; these were included to provide the context for the terrain in which individual decision-making takes place. The primary inclusion criteria applied to literature on the legislation and the role of the AMHP was that articles should be from January 2007 to the present day. This is because 2007 is the year when the role of AMHP was created through royal assent. There were however some exceptions. For example, the longitudinal nature of some studies mean that they predated 2007 at their commencement, and this explains why they refer to the role of the Approved Social Worker (ASW) rather than the AMHP. These studies are included as they offer important insights and represent some of the most up to date research of this role under the MHA. The literature review also includes articles on decision-making and mental disorder prior to 2007, as this research has continuing relevance in terms of a more general understanding of risk assessment in social work practice. Social work decision-making was included as 95% of AMHPs nationally are social workers by profession (Adass, 2018). There was no date restriction used on the published literature about

psychiatry, mental illness and critical theory, although as a rule the most up-to-date research was accessed, excepting for classic texts or original studies that have not been updated. This was to ensure that a historical perspective on the development of theoretical and critical approaches was included. The only other pre-selection criteria used was that articles should relate to the key themes of the study.

A scoping method was then adopted to gain an overview of the current literature and to undertake a mapping exercise. Although the term 'scoping review' is somewhat ambiguous (Arksey & O'Malley, 2005), I followed a process similar to the one identified by Arksey & O'Malley (2005) which included identifying an initial research question and the studies relevant to this question (Daudt, van Mossel, & Scott, 2013). Articles relating to the research problem that was being explored in this study (factors that influence AMPH decision-making) were reviewed and charted by collating key themes and summarising the evidence. This led to a clearer focus for the area of study and identified the gaps in knowledge the research aimed to address (Armstrong, Hall, & Waters, 2011). Finally, the information was collated and summarised thematically to form the literature review. This method does not seek to take a view regarding the weight of the evidence or to critique the methodology of research studies; it is an attempt to identify what is currently known about the problem or social situation under study. In addition to scoping the research into decision-making under the MHA by AMHPs, the review includes literature relating to social work decision-making more generally and articles on contemporary debates about mental disorder. This provides the context within which AMHPs operate.

The scoping method enabled me to identify the key areas of debate in mental health and research relating to the work of AMHPs. This has been continued to be updated throughout the process of undertaking and completing this research.

The literature review is organised under several headings. Each section contains an introduction to provide the rationale for focusing on the topic under discussion, and each section is completed with a concluding statement that summarises the value of the discussion to the study. At the end of the literature review, a summary of key issues is provided.

## 2.3 Towards an understanding of mental illness

The language of mental illness is varied and contested which reflects different perspectives including realist, constructivist, and critical realist perspectives (Pilgrim, 2017). These diverse standpoints are a factor that needs to be considered when analysing the different perspectives that AMHPs hold and the beliefs about those they encounter during the process of mental health act assessments (MHAA). The literature reviewed below reflects the use of a wide range of terms, just in the titles of the publications and the descriptions contained within. These include 'Mad' (Whittaker, 2002), 'Madness' (Newnes, Holmes, & Dunn, 1999), 'Mental Illness' (Szasz, 2010), 'Mental Disorder' (Jones, 2019), 'Mental Distress' (Tew et al., 2005) 'Mental Health' (Tew et al., 2005), 'Psycho' (Sedgewick, 1982) and 'Crazy' (Kutchins & Kirk, 2003). The titles do not necessarily represent the view of the author as Szmukler (2018) explains in his book *Men in White Coats*; sometimes the writer chooses a title as it captures the essence of popular culture and language relating to that subject. As this research thesis was completed the term 'Psycho-social disability' was increasingly entering the language in this field due to the influence of the Convention on the Rights of Persons with Disabilities (CRPD) (Gooding, 2017).

The difference in terminology itself reflects the contested nature of the debate about mental disorder, a debate which is as old as human civilization (Scull, 2015). The histories of mental illness identify religious explanations that can be evidenced in ancient civilisations to the modern day. Furthermore, physical explanations and psychosocial explanations can also be traced back to their origins in the theories of antiquity (Scull, 2015; Kutchins & Kirk, 2003; Ferguson, 2017).

The MHA does not give a definitive definition of mental disorder other than "any disorder or disability of the mind or brain" S1 (2) but stipulates the presence of mental disorder as one of the criteria which must be present when considering compulsory powers. Each section of the MHA allowing the use of compulsory powers states, "he is suffering from mental disorder of a nature or degree....." (2) (a). Nature refers to the type or diagnosis of disorder and degree relating to its manifestation or acuity. This concept is therefore enshrined in the law guiding the decisions of AMHPs and other mental health practitioners.

## **“Illness” and Psychiatric Positivism**

The terms mental illness and mental disorder place the understanding of mental distress or dysfunction within the model of medicine or psychiatric positivism (Pilgrim, 2017). The term mentally ill is now pervasive within literature, mental health services and society in general. Writers such as Porter (2003) view this as a positive progression and see the classification and treatment of mental illness as part of the 20<sup>th</sup> century’s great breakthrough in the battle against disease. The identification and classification of conditions such as bipolar disorder or schizophrenia, and the subsequent prescribing of Lithium or Thorazine, are seen as comparable with the isolation and treatment of conditions such as smallpox or tuberculosis (Porter, 2003). But for others, such as Cohen (2016), medicalisation reflects neo-liberal concepts of individual pathology and deviance.

This psychiatric positivist concept of mental illness supports the belief that there is an aetiology for a condition and, therefore, a pathogen or identifiable cause. In the case of depression, the causal factor is believed to be the brain chemical serotonin – and with schizophrenia, the brain chemical dopamine. The isolation of chemical causation of mental illness for the positivists creates the possibility of chemical treatment for the illnesses; this has led to the introduction of selective serotonin reuptake inhibitors (SSRI) for depression and neuroleptics for psychosis (Frude, 2004). The use of the popular terms, such as anti-depressants or anti-psychotics, is believed by Whittaker (2010) to be an attempt to attach to medication the same efficacy as pathogen-fighting antibiotics or anti-malaria medication. The prefix ‘anti’, Whittaker believes, is used to endow upon the medication the status of a disease-defeating treatment. Whittaker (2010) gives the example of the comparison with diabetes, which he believes has become a common metaphor in psychiatry for convincing the patient that they have a chronic lifelong illness requiring long term treatment with medication. This critical approach to psychiatric positivism is supported by Pilgrim (2014), who describes the ontological claims of positivist psychiatry as an “epistemological fallacy”. In other words, psychiatry has convinced us ideologically of its evidence base, but these claims are limited in their reliability. Pilgrim describes the evidence base of much psychiatric positivism as tautology, in that the diagnosis is justified by the symptoms and symptoms are explained by the diagnosis – without any independent evidence such as the identification of the aetiology or causative mechanism.

The impact of this contested area of understanding has significant implications as the legal definition of mental illness has status in law (although in law the term used is mental disorder). The MHA defines mental disorder as ‘any disorder or disability of the mind’ S1 (1). The MHA goes on to state that the presence of a mental disorder should be determined by a relevant professional using “good clinical

practice and accepted standards of what constitutes such a disorder or disability". The definitions of what constitutes a mental disorder are broadly in line with categories of mental illness outlined in the International Classification of Diseases (ICD) produced by the World Health Organisation and the Diagnostic Statistical Manual (DSM) produced by the American Psychiatric Association (APA), although other presentations of mental disorder are not excluded (Jones, 2019).

The CoP/MHA states that there needs to be an appreciation of cultural and social differences between people when diagnosing mental illness and behaviour that constitutes mental illness with one individual may not be indicative when it comes to another. Practitioners are discouraged from using preconceptions to diagnose or avoid diagnosing mental disorder (DOH, 2015). The guidance to the MHA also clearly precludes diagnosis purely on the grounds of religious, cultural, or political beliefs, values or opinions. This remains true even if the behaviour appears to be unusual or creates distress, anger, or danger for others. Although it also states that these types of beliefs or behaviours can be included if there are clinical grounds to believe that they are part of a "disability or disorder of the mind" S1 (1). The same is also true of illegal, anti-social or what is perceived to be immoral behaviour (DOH, 2015).

The belief that there is such a thing as mental illness which manifests in the same way as physical illness has been subject to challenge throughout the history of psychiatry and psychotherapy (Whittaker, 2002). Both these traditions have been subjected to criticism by the anti-psychiatry movement, including radical writers of the 1960's such as Szasz, Goffman, Laing and Foucault (Sedgewick, 1982). There are significant differences in the criticisms each of these writers present in relation to established beliefs regarding the defining of mental illness, but they all take issue with the notion that mental illness/disorder can be separated from societal beliefs and power structures (Sedgewick, 1982; Moncrief, 2008). For example, Szasz (1974) adopts a libertarian perspective and suggests that mental illness is a metaphorical and not a physical condition, and that there is no justification to use the term 'illness' unless there is physical evidence of a biological illness. Therefore, any attempts by the state or medical profession to impose clinical assessment is, at best, misguided – and without medical evidence, clinical assessment lacks foundation.

Sedgewick (1982) challenges the notion that physical illness itself is free from subjectivity as nature does not have a view on whether a virus is an illness. Sedgewick argues that all illness is a form of deviance, whether it is physical or mental illness, because it differs from what society considers a

desirable physical or mental state to be. It is binary logic which leads to the separation of mind and body and requires a dualistic approach that separates the treatment of metaphoric symptoms from symptoms that are organic (Bracken & Thomas, 2010). Pilgrim (2017) argues that Szasz and Goffman adopted a dualist approach to their ontology and epistemology regarding mental illness or disorder, in that they separated what they believed to be real illness (organic/physical), from what was constructed externally in the form of diagnosis or institutions designed to contain the deviant.

Foucault viewed the understanding of mental illness from a social constructionist perspective (Burr, 2015) and the specific role that knowledge or beliefs play within the structures of a given society. He recognised that power was a significant factor in the identification, diagnosis and treatment of mental illness but did not necessarily see this as a negative phenomenon. The important consideration was whether the beliefs and power were based on a technical rational foundation. If they were, Foucault believed they could be a force for positive change if these beliefs were subject to internal and external criticism (Bracken & Thomas, 2010). A Foucauldian approach would take the view that psychiatry and psychotherapy were not separate entities, but part of a whole in terms of the technical knowledge and procedures of an advanced society. Critical psychiatry, as opposed to anti-psychiatry, has been suggested as a more accurate description of the approach to psychiatry proposed by Foucault (Sedgewick, 1982). Although Foucault acknowledges the mistreatment of asylum inmates, the disciplinary power of the institution and the role of psychiatry within this, he proposes a critical approach to psychiatry rather than an attempt to simply dismiss it (Foucault, 1988). Foucault wrote extensively on the epistemology of understanding mental illness through language and discourse. He also used this constructivist model to understand the development of professional psychiatry and its institutions. Foucault's reflections on the ontological question or lived experience of the mentally distressed was less prominent, as his focus was primarily how we socially construct reality (Burr, 2015).

Psychiatric positivism as a basis for understanding mental illness has been challenged by several writers (Whittaker, 2010; Moncrief, 2008; Watters, 2010; Kutchins and Kirk, 2003). These range from direct challenges to a perceived over-reliance on a brain disease model of mental distress (Moncrief, 2008; Whittaker, 2010), to critiques of the diagnosis and definition of mental illness. The brain disease model argues that chemical imbalances are the basis of mental illness, and that these imbalances can be addressed with the use of anti-depressant and anti-psychotic medications. Moncrief (2008) presents an alternative model, which she called the drug-centred model. The evidence Moncrief (2008) presents is that the medication prescribed for mental illness does not have the drug action that

it is claimed to have. She contends that medication for mental disorder, does not address underlying disease aetiology by correcting imbalances. Instead Moncrief proposes a drug-centred model which suggests that medication, far from addressing underlying causes and therefore diminishing symptoms, works on the symptoms by creating a blunted effect in the person that gives the appearance of a cure. Moncrief (2008) also contends that what are believed to be relapses into acute illness are, quite often, the effects of the medication itself or the effects of withdrawal syndrome related to prescribed medication. Therefore, whilst accepting that people experience mental distress as real and do to some extent experience relief from distress by taking medication, Moncrief does not accept the claims of psychiatric positivism about the biological aetiology theory of mental illness.

This belief is supported by Whitaker (2010), who suggests that there is no evidence to support the belief that there is a significant difference between the brains of those believed to be mentally ill and those not experiencing mental illness, when it comes to the production of dopamine or serotonin. He argues that where any difference exists, it is not because of a pre-existing condition but because neural adaptation has taken place in the brains of those taking medication. In other words, the difference in brain structure that researchers identify is caused by taking antipsychotic medication itself.

Whittaker (2010), drawing on experience from the United States (USA), believes that there is a commonly held assumption about mental illness that, from the 1950s onwards, that chronic mental illness has gradually disappeared because of medical breakthroughs and the introduction of more sophisticated anti-psychotic and anti-depressant medication. Whitaker has used independent as well as pharmaceutical industry research to track the trends of incidence of mental illness, recovery, and long-term outcomes. He compared the numbers of people in receipt of disability payments for mental illness over a period of 20 years. In 1987, 1 in 184 of the population were receiving this benefit; by 2007, this had risen to 3.97 million, or 1 in 76. A similar increase also happened with the diagnosis of childhood mental illness. In 1987, there were 16,200 children in the USA on disability payments for mental illness, by 2007 the figure was 561,569. This evidence, Whittaker suggests, directly contradicts commonly held beliefs about the efficacy of the new generation medications.

Whittaker (2010) contends that the rise in chronic mental illness can be directly linked with the increasing dominance of the biomedical model of mental illness. He argues that three major interest groups had a vested interest in the promotion of this model of mental illness. Firstly, the pharmaceutical industry for financial reasons, secondly, psychiatry needed to regain its credibility as

a field of medicine and finally, groups who favoured approaches that pathologised the disease rather than blaming the individual or their family.

Whittaker (2010) uses international comparisons to show that outcomes for recovery in psychosis in developing countries are often better than those in the more economically developed. Various theories have been suggested, such as family and community structures, less dependent cultures, and the necessity of returning to employment, amongst others. Whitaker suggests another factor, which is the reduced likelihood of people being prescribed anti-psychotic, anti-depressant, or mood stabilising medication. He cites studies which show the increasing chronicity of mental illness in developing countries as these medications are introduced, and reduced chronicity as these medications are prescribed less frequently (Whittaker, 2010).

### *Summary*

In conclusion, the disparity in the beliefs of those writing about mental illness highlights the contested debate regarding mental illness and its definition, classification, causes and possible solutions. The framing of an AMHP's understanding contains all the competing elements of science, culture, ideology, and language. The AMHP role is part medical, part legal and, also contains elements of social critique and encompasses all of these competing tensions. This required consideration during the analysis of evidence from AMHPs in discussion about their practice and the beliefs that shaped their understanding.

## **2.4 Diagnosis and the DSM**

The issue of diagnosis and its validity or accuracy is another factor that potentially impacts upon the decision-making of AMHPs. The "nature" of a mental disorder is one of the qualifying criteria for detention using the MHA. The Diagnostic Statistical Manual (DSM) is one of the key references for psychiatrists when identifying and diagnosing a mental disorder or mental illness. The following section is a brief look at critiques of the DSM.

The belief that objective scientific research is the basis for categorisation and classification of mental illness is challenged by Kutchins & Kirk (2003) in their history of the DSM. They state that the DSM definitions of mental disorder firmly place mental illness as a phenomenon that is rooted in the individual - an internal dysfunction of the individual's psyche and not a cultural or transactional

deviance. Kutchins and Kirk believe the intention behind this is to give psychiatry the same standing as other branches of medicine. In other words, it is individual pathology that is treated not culture, values, or societal expectations. Kutchins and Kirk use the American Psychiatric Association (APA) debates around defining disorders as a way of highlighting the way in which societal values, shifting internal power structures of the APA and political campaigning, including direct action, have influenced the classification of mental disorder. For example, the American Vietnam Veterans Association (AVA) and the Gay Liberation Front (GLF) both sought to change the DSM by political campaigning. The GLF wanted homosexuality removed as a criterion under the sexual deviations category and the AVA organised protests for the inclusion of Post-Traumatic Stress Disorder (PTSD).

Kutchins and Kirk (2003) also contend that the values and beliefs of wider society and societal structural inequalities are reflected in the construction of diagnoses. Two examples are included that reflect what they see as the gender bias of a male dominated profession. Masochistic Personality Disorder and Borderline Personality Disorder have been heavily criticised by feminist psychiatrists because they include behaviour traits that appeared to blame or pathologise women for being less successful/subservient to powerful men or for having the ability to manipulate the actions or behaviours of others. Historical racism in diagnosis is also highlighted. The example given is of 'Drapetomania', a diagnosis that was applied to slaves who would not accept the dominant racist belief that there were benefits of being a slave (Kutchins & Kirk, 2003). The history of racism in society and in psychiatry is presented by some writers as an explanation of the continuation of the high number of people from particular black and minority ethnic communities (BME) being disproportionately diagnosed with schizophrenia and being subject to the more restrictive elements of mental health legislation (such as forcible medication) (Patel & Fatimilehin 1999; Ferns, 2005). This problem is said to arise from Western perspectives or Eurocentric approaches that problematise the behaviour of others, and from the unequal power relations that exist between service users and practitioners (Ferns, 2005).

The approach taken by the APA in the development of the DSM is described by Pilgrim (2017, 2014) as a tautological approach. A Psychiatric disorder such as schizophrenia is diagnosed, and the behavioural presentation of the patient proves this to be a correct diagnosis. The question asked is why the patient behaves in such a way, and the answer is because they have schizophrenia. The next question is how we know the person has schizophrenia, and the answer is because of the way they behave. There is no deeper explanation given that can justify the diagnosis based on aetiology,

Kutchins & Kirk (2003) describe the process of identifying and classifying mental disorder in the DSM, using the process by which the APA invites its members to write papers identifying what they believe to be identifiable mental disorders. These disorders are then debated, discussed, and voted upon by conference committees without any significant medical research, including the establishment of an aetiology.

Watters (2010) investigated what impact these belief and treatment systems have on industrialised countries including USA, Denmark, Sweden, Taiwan, where there is greater access to healthcare, the latest medical treatments and talking therapies. Watters found these countries have poorer outcomes for those with a mental illness compared to less wealthy countries such as India, Nigeria and Colombia. He rejected what he considered to be stereotyped beliefs such as people in less wealthy countries needing to remain economically active, work being less demanding, the role of extended families offering support or notions of these societies having simpler social roles. Watters emphasises more complex cultural factors:

“Looking at ourselves through the eyes of those living in places where human tragedy is still embedded in complex religious and cultural narratives, we get a glimpse of our modern selves as a deeply insecure and fearful people. We are investing our great wealth in researching and treating this disorder because we have rather suddenly lost other belief systems that once gave meaning and context to our suffering” (Watters, 2010, p. 135)

World Health Organisation studies cited by Watters (2010) show that there are higher rates of schizophrenia diagnosed in urban areas compared to rural areas of Europe and the USA. In studies comparing developing with advanced industrial countries, the evidence shows that symptoms experienced were less severe, periods of remission without relapse were longer and levels of long-term social functioning were much better. On average, in industrialised countries, 40% of those diagnosed with schizophrenia were severely impaired by their illness, as opposed to 24% in less wealthy countries.

Watters uses case studies from around the world including anorexia in Hong Kong; post-traumatic stress disorder in Indonesia following the Tsunami; schizophrenia in Zanzibar and depression in Japan.

With each case study, he illustrates how traditional beliefs and ways of coping with trauma or mental distress have changed because of the influence of western psychiatry, pharmaceutical companies and non-governmental aid agencies. Watters suggests that western notions of illness, where accepted, appear to have created the belief that mental illness is a chronic lifelong medical illness that requires medication to control symptoms or technical therapies to address mistaken beliefs. This process, Watters believes, has globalised our understanding and perspectives of mental health and illness.

Watters (2010) argues that, unlike the reflex actions of muscles, human emotions are about communicating something that is more deeply rooted and whose meaning may be obscured. The way in which these meanings are communicated can be based on historical circumstances, for example the belief that our minds and bodies are controlled by others using technology is only possible in the modern age where such technology exists. The values and beliefs that are dominant in society are also influential on the symptoms of mental illness experienced. For instance, delusions of guilt are more prevalent in countries with Judeo-Christian cultures, as are hallucinations about hearing the voice of God. In Pakistan, hallucinations that involve ghosts or spirits are common and, in villages in South East Asia, delusions of grandeur are practically unknown. Watters puts this down to the fact that striving for personal status is frowned upon. The USA is almost the reverse of this, something that Watters (2010) believes relates to values of self-promotion and the desire for fame.

### *Summary*

The nature of mental illness/disorder is a central question for AMHPs; in particular, when to detain someone either for treatment or assessment. What are they seeking to assess in an acute psychiatric ward where the person's behaviour is being assessed out of the context of their own environment? When a person is detained for treatment of a mental illness what beliefs underpin the decision? The contested nature of mental illness, and subsequent contested ideas about treatment and containment of symptoms of mental disorder, are directly connected to the purpose of mental health legislation and the role of the AMHP within that legislation. The possible explanations for the existence of these schools of thought about those deemed to be mentally ill are further explored below.

## 2.5 Neo Marxian and Critical Realist Approaches

Cohen (2016) presents what he describes as a Marxist analysis of mental illness. He acknowledges the contribution that critical perspectives have made in helping to deconstruct the dominant medical illness narrative in mental health. However, he states the belief that none of these writers have put these critiques of medical models or critiques of social policy into a general theory of understanding and therefore lack sustained theoretical engagement. He also proposes that part of the difficulty with previous attempts at developing a Marxist theory of mental illness, is that they have been written from within what he describes as the 'psy- professions'. Cohen (2016) uses this term throughout his book to describe any professional working within current mental health services, including psychiatrists, psychologists, psychiatric nurses, social workers and others. He infers that these writers begin from a fundamentally flawed perspective that is deeply influenced by the dominant ideology of capitalist society which is both bio-medical and consciously designed to maintain capitalism and its current Neo-liberal form. Cohen is highly critical of the 'psy-profession' and what others (Pilgrim, 2014) would call psychiatric positivism. Cohen states that these dominant beliefs are not only held by the psychiatric profession but all associated professions within mental health provision.

Cohen presents historical and empirical evidence drawn from writers such as Whittaker (2010), Moncrief (2008), Watters (2010), Kitchens and Kirk (2003) and Scull (2015). He uses what are described as classical Marxist theoretical concepts to theorise how and why those experiencing mental illness have been detained in hospitals, medicated and mistreated in such large numbers. Cohen's history of the psychiatric profession describes his belief that, over last 200 hundred years rather than caring for the most vulnerable, the 'psy-profession' has compounded their distress and, and has been an ideological champion for the Poor Law, slavery, eugenics, homophobia and the oppression of women.

Cohen draws on classical Marxist theory such as base and superstructure to theorise the existence of the psychiatric profession and also the reason for its perceived complicity in the mistreatment of the mentally ill. Cohen uses base and superstructure as a theory to contend that the dominant economic organisation of society (base), in this instance capitalism, is intrinsically linked to the institutions and laws of that society (superstructure). In other words, capitalism is, at its foundations, a system based on exploitation, inequality, and oppression, therefore its institutions will reflect the need for capitalism to be able to maintain these relations of exploitation.

This theoretical framework is used to theorise how or why the psychiatric profession complied with dominant views such as racism and even assisted in the ideological maintenance of slavery through the development of diagnosis such as Drapetomania and Dyaesthesia. Cohen contends that this also explains the complicity of psychiatry with the eugenic programme during the Holocaust in Europe. He applies similar theoretical arguments to explain the use of psychiatric medication for school aged children under modern neo-liberal capitalism. Cohen links the history and development of compulsory education to the development of industrial capitalism and proposes that the structure of the school day and content of what is taught is a direct reflection of the needs of capitalism. In the form of a section of society that is docile and accepting of their role and place. Cohen cites examples of diagnosis such as Oppositional Defiance Disorder/Attention Deficit Disorder, and the subsequent medicating of these children, as evidence of this. This method of understanding is further extended by Cohen to the psychiatric treatment of women and LGBTQ+ people, in order to defend the dominance of patriarchy and the institution of the family.

Ferguson (2017) sets out with the same aim as Cohen (2016) to understand mental illness, its definition and treatment within a Marxist framework of understanding. Ferguson gives an historical overview of how mental illness has been defined and understood. Also, how those considered to be mentally ill have been confined and treated. Ferguson provides an ideological history of how the dominant medical view of mental illness originated and how this is maintained through the ideological hegemony of the ruling elites within society. The classical Marxist theories of political economy and alienation are also applied. Ferguson contends that the dominance of the capitalist mode of production has a profound impact on the human psyche. Ferguson uses the classical theory of alienation, as developed by Marx, to explain the intensified expressions of mental distress under capitalism. Whilst not dismissing the existence of mental illness prior to the advent of industrial society, Ferguson contends that the intensification of competitive exploitation and the loss of control of the mind and body in this process is historically unique. Ferguson applies the theory of alienation to explain how this process of alienation throughout the history of capitalism but particularly in late neo liberal capitalism has led to increasing levels of mental distress.

Ferguson (2017) also attempts to explain the historical development of our understanding of the human mind and mental illness. He contends that the dominance of psychiatry or medical models fits

with the dominant ideas of individualism and individual responsibility. If mental illness is rooted within the individual's biology or because of the individual's moral choices, then the cure lies with treating the individual, their symptoms and/or behaviour. His evidence for this is the moral treatment evident in the early asylums, such as The Retreat in York overseen by William Tuke and the physical treatments including psycho-surgery, electric convulsive therapy and pharmacology that have prevailed throughout the history of psychiatry, beginning with the contentions of Kraepelin a German psychiatrist of the 19<sup>th</sup> century who is considered to be the grandfather of psychiatric positivism (Ferguson, 2017).

Ferguson's history of theories relating to mental illness also includes those that have been critical or have run in parallel, including psychotherapy, radical psychology and the anti-psychiatry movement of the 1960's. Ferguson points to critical elements of Sigmund Freud and psychotherapy in identifying the relationship between human development, experience, sub-conscious processes and the expressions of this through mental illness or neurosis. Ferguson describes many of these contentions by Freud and other psychotherapists as the radical kernel of psychotherapy, whilst acknowledging how much of the radical elements of this thinking was medicalised and mainstreamed following its adaption to a respectable therapy in the post-war United States.

Ferguson's historical account contends that an understanding of the human mind and mental illness is controlled through ideological hegemony and also shows how the history of this hegemony is punctuated by radical challenges such as by Freud in the late 19<sup>th</sup> Century, Fromm, Vygotsky and Voloshinov in the aftermath of the Russian Revolution and by critical thinkers such as Foucault, Laing and Goffman, who gained in popularity due to the general challenges to orthodox thinking during the 1960s. Ferguson does not explain mental illness or its understanding as a static entity; Ferguson contends that there is something unique about human consciousness as expressed by Karl Marx in his theory of Alienation. The expression of mental illness is contextual both in terms of the person's history/experiences and the social context within which they are living. A range of factors including social class, ethnicity, gender, sexuality, religion, age, and other factors mediate our relationship with our environment and these experiences are internalised. These factors, and the nature of the society in which we exist, will also influence how behaviours are understood and what formulations flow from this. Equally, this will also determine how we are then treated.

Pilgrim (2014), in various writings, describes his approach as Critical Realism rather than Marxism, although he acknowledges the contribution of Marx, as well as Durkheim and others, to the school of Critical Realism. Pilgrim uses the work of Sedgewick (1974) as a starting point of the discussion about mental illness, in particular the concept that all illness, not just mental illness, is a form of deviance, as physical illness is considered as part of human normative processes and contains subjective judgements about the individual's efficiency and performance.

Pilgrim questions what is real about mental illness and what can be confidently claimed as true. Pilgrim distinguishes Critical Realism from the Naïve Realism of Psychiatric Positivism and the Relativism of Social Constructionism (Burr, 2014). Pilgrim believes ontologically that there is such a thing as reality or intransitive reality which exists separate from human knowledge and would pre and post-date human existence. Pilgrim qualifies this with the epistemological concept of transitive reality, which is the world as we know it or believe it to be. Pilgrim believes psychiatry turns the transitive phenomena of human behaviour in the form of symptoms into the intransitive assumptions of diagnosis by creating the epistemological fallacy of diagnosis which mistakes symptoms of an illness for signs. In medical terms, signs would be the aetiology of an illness or, put simply, a sneeze is a symptom of many illnesses.

This critique of psychiatric positivism also considers the epistemological reality of diagnosis and the fact that, once these diagnostic criteria become commonly held beliefs by professionals and lay people, they become part of everyday reality. Pilgrim's view is that these beliefs are context bound but the reality is some people behave in unintelligible or incorrigible ways which concern others, particularly when they happen in public spaces. This disruption to everyday life and expectations leads to what Pilgrim describes as the disruption of role achievement or role compliance and, even if the person has full insight, these presentations break the normative emotional rules. It is this disruption to everyday life and potential reduction in economic efficiency that draws the attention of government which seeks to manage this disruption through mental health legislation and policy. Within this process there will be pre-eminent occupations that have control of the labelling process and ultimately the amelioration of this disruption through treatment and/or forcible incarceration.

Pilgrim believes that psychiatric positivism makes wide-reaching ontological claims about diagnosis and treatment. He argues that psychiatry is limited in its ability to make these claims, as mental illness

diagnosis is flawed across a range of diagnostic requirements, such as a physical test to identify a cause/aetiology, lack of clear boundaries in diagnosis which often leads to diagnosis of comorbidity, poor treatment outcomes, unreliable predictions regarding prognosis and low levels of satisfaction from those being diagnosed with the diagnosis they have been given.

### *Summary*

The understanding of mental disorder, its symptoms and treatment is an element of AMHP training and practice. The competing perspectives of mental illness or mental disorder influence the way in which AMHPs frame their understanding of the problem situation that they are presented with and goes to the core of how AMHPs understand human behaviour and the question of whether there is an objective reality that can be understood. This will also influence the decision in relation to what an AMHP believes their course of action will achieve or prevent. The next section looks at how risk concerns associated with mental illness are framed and interpreted.

## **2.6 Risk and Dangerousness**

The detention of people defined as mentally ill and their treatment either forcibly or coercively is a contested issue. The dominance of the risk agenda in mental health is evident across the literature despite there being no direct reference to it in the MHA (Glover-Thomas, 2011). Szmukler (2018) asserts that very little has changed over the past 200 years in relation to the rationale for detaining those with a mental illness, the detention criteria essentially being the identification of the presence of a mental disorder and the perception that this person poses some kind of risk to themselves or others. Pilgrim (2014) concurs with this assertion and the belief that this is reinforced through a dominant cultural view that associates mental illness with violence, despite there being very little empirical evidence to support this connection.

Pilgrim (2014) found that the only evidence that supported the narrative that those with a mental illness were more violent than the general population was in relation to two specific groups, those misusing drugs or alcohol (dual diagnosis) and those diagnosed with anti-social personality disorder. Both of these diagnoses were considered to be contentious, as to whether they should be considered as constituting a mental illness and therefore warranting a clinical diagnosis. This aside, the main

concern was that it was those with a diagnosis of a psychotic illness who were generally perceived to be dangerous. Ramon (2005) believes that this is part of the general discourse of risk and mental illness which is reinforced by narratives and images in the media. Sayce (1999) points to how the media attaches risk and dangerousness to mental illness in both the news media and culture. Sayce asserts that there is a long tradition in popular culture of the dangerous character in films and literature having some kind of mental illness. These representations persist despite the only evidence of increased violence by people with a psychotic illness is amongst people who have coexisting substance misuse problems or dual diagnosis. Therefore, the risk arising from substance misuse is a general risk which exists across most groups in society and is not exclusive to those who are mentally ill (Pilgrim, 2014).

Szmukler & Rose (2013) point to the statistical rarity of violence being such that there is no empirical evidence to justify focusing on those with mental illness as a group that poses an increased risk to others. There is more evidence to suggest closer monitoring of those who drink alcohol and drive a vehicle or those convicted of domestic violence. The reason given for the focus on the mentally ill is what Szmukler & Rose describe as the associated “moral outrage” (p. 126), because an act of violence has been carried out by a person perceived to be from a group where violence is believed to be more prevalent, the media and others give it increased attention and question why nothing was done to prevent it. These events are then followed by enquiries which make recommendations for changes which create a “plausible narrative” (p. 127) that lessons can be learnt so restoring trust in public institutions and the belief in their ability to keep society safe.

Ramon (2005) states that there seems to be a greater emphasis on the management of risk in the United Kingdom. Although no specific explanation for this is given, Ramon contends that generally western societies expect people to self-regulate their behaviour and when they deviate from this norm, external regulations are put in place to ensure conformity. Because mental illness becomes a threat to social cohesion, politicians and legislators create professional roles to monitor the harm people may cause themselves or others. Warner et al. (2017) believe that people with a mental illness have been caught up in the general risk narrative or public protection agenda that dominates the neo liberal political discourse. They describe how ideologically framing mental health as a problem located in the individual, places blame on that individual and those managing them when harm to self or others occurs. This has led to the use of performance targets and performance management to

measure outcomes in public services, which then allows those who hold power to construct a discourse of blame that can marginalise unpopular groups such as the mentally ill and social workers. Ramon (2005) supports this view that we have shifted from focusing on preventing harm to the person who is mentally ill to a focus on damage limitation to the reputation of the practitioner or the organisation they represent.

This focus on managing risk is identified as having an iatrogenic effect on the person who becomes subject to compulsory detention or treatment in the community, Pilgrim (2014) identifies these iatrogenic effects as the loss of liberty without trial, coercive treatment with associated negative side effects and becoming victims of violence because of the lower socio-economic status associated with being a mental health patient. Szmukler (2018) also points to the negative resource impact of spending large amounts of time on unnecessary risk training and workers filling out prescriptive risk assessments that have no proven efficacy. The outcome of this process being an emphasis on avoiding false negatives (missing someone who does harm themselves or others) rather than recognising false positives (detaining people when the evidence suggests low risk of harm) which are possibly more harmful to the individual and society in the longer term.

Campbell & Davidson (2017) assert that the greater risk, is the iatrogenic risk to the individual, created by the deprivation of liberty and associated inequalities which are a product of this process, including the labelling of the mentally ill and resultant social stigma. Rather than violence being a product of mental illness, the process of becoming a mental health patient and the related socio-economic and health inequalities place people at more risk of substance misuse, violence, and suicide. The effect on socio-economic wellbeing and environmental risks are cited as the reason for this.

Warner et al. (2017) identify that professionals are partially responsible for the iatrogenic consequences of mental health work, as they have promoted the belief that mental illness can be objectively diagnosed and the associated risks predicted and managed, or as Pilgrim (2014) contends mental health work is based on an epistemological fallacy. Campbell & Davidson (2017) describe how the codification of professional roles has created an associated custom and practice that is used to construct a picture of the person and their circumstances which creates an optimism about the capacity to calculate risk which is misplaced. Szmukler & Rose (2013) describes this as giving the appearance that we can bring the future into the present and therefore make risks calculable. This

belief is reinforced by risk assessment tools based on the findings of others that reassure us that something can be done to manage risk and ultimately find someone to blame if things go wrong. This “risk colonization” (p. 135), as Szmukler & Rose describe it, now dominates the work of healthcare professionals to such an extent that it damages therapeutic relationships and tends to increase risks rather than reduce them.

The risk agenda is identified here as dominant discourse in the areas of mental health law, policy, and public perception, it will be discussed again later in the literature review in relation to how this impacts on practice.

### *Summary*

The literature covered so far has scoped the field of debate around the ideological debates about mental illness. This provides the context within which all mental health legislation and professional decision making is underpinned and boundaried. The literature touches upon the codification of mental illness as a disorder, how this codification is used to inform legislation and the role of professionals. There is nothing in the review of the literature at this point that identifies how AMHPs position themselves within this debate.

In the next section I look at the legal, policy and other processes used by social workers, AMHPs and other healthcare professionals when considering assessment of mental illness and reasons for possible intervention. This includes the way in which the social workers, AMHPs and other healthcare professionals construct and deconstruct their frameworks of understanding. This does include some research findings that look at how mental health professionals, some of whom include AMHPs, consider the question of mental disorder and associated risk. Some of this literature also includes how these considerations take place within a legal framework and other factors relating to this.

## **2.7 Assessment and Decision-making**

In this section, I explore some theories of decision-making and their application to AMHP, social work and mental health practice. This includes elements of decision-making from all mental health practitioners but the primary focus of the discussion at this stage is the decisions of social workers, as according to Adass they continue to make up the majority of the AMHP workforce (Adass, 2018).

The complexity involved in understanding professional decision-making is recognised by writers such as Schon (1991), who identifies the conflicting influences of factors such as values, purposes, goals, and interests. Schon (1991) not only highlights these influences, but also the necessity for professionals to be able to combine these influences to make decisions. One of the effects of this complexity is the difficulty it creates in simply describing the process by which decisions are made, although an awareness of this is identified as an important step in making defensible decisions: “We are bound to an epistemology of practice which leaves us at a loss to explain, or even describe, the competences to which we now give overriding importance” (Schon, 1991, p. 20).

Schon (1991) describes how professionals start to construct from materials that at first make no sense and then create meaning from this same material. This process is described as problem setting. An interactive process which results in the professional naming or framing the problem. It is this problem setting or mapping of the problem which allows them to solve a problem by applying an existing theory or technique to the situation. This is an active process of using knowledge in action, in which the professional may appear to be acting instinctively but uses previous experience and knowledge to assess, interpret and act on a situation.

The claim to specialist knowledge and application of that knowledge is how Schon (1991) believes professions maintain their status. Social work had the status of what he described as a minor profession due to shifting ambiguous ends and unstable institutional practice, which created difficulties in developing “systematic, scientific professional knowledge” (p. 23). This positivist approach using technical rationality in the physical sciences, and the more prescriptive professions such as law and medicine, is not without its own difficulties, including maintaining objectivity and reliability. Schon believes this is even more difficult to achieve for professions such as social work which draws more of its evidence base from the social sciences.

This process of framing is discussed by other authors (Strachan & Tallant, 1995; Russo & Shoemaker, 1992; O’Sullivan, 2011), and there appears to be broad agreement on the necessity or inevitability of this process as a way of rapidly collating available information, interpreting this and then framing the problem to be addressed. Adopting mental frameworks such as this enables us to simplify and structure the information to keep complexity within dimensions that our minds can manage (Strachan & Tallant, 1995). The limitations and potential problems of this process are acknowledged, particularly

when the professional adopts only one frame to the situation which can result in them only having a partial view. Strachan & Tallant (1995) identify three forms of bias that can negatively affect professional decisions. These are representative bias, which stems from restricting analysis to seeing all situations as the same as previous situations that have similar characteristics; availability bias, basing decisions on what we remember without factoring in the inconsistencies in our memory and confirmation bias, when the professional seeks to confirm a preconception by seeking only the evidence to confirm what they are already thinking.

Using the framing process can potentially create positive outcomes when the professional is conscious of it, but this requires a critical or reflexive approach that factors in the possibility of confirmation bias (O'Sullivan, 2011). O'Sullivan identifies three key stages of framing in which reflexive practice is essential. These are described as constructing pictures of the situation, formulating outcome goals, and then building options. Strachan & Tallant (1995) call this process de-biasing and see the involvement of service users in the process of framing as essential in constructing less oppressive outcomes, as their lived experience can assist in balancing out the professional's perception.

A concrete example of the possibilities and potential problems associated with decision-making is presented by Menon (2013) in a review of suicide risk assessment. Menon believes that the traditional approach in psychiatry is risk prediction, which is dominated by the forensic tradition of predicting risk based on the individual's previous behaviour. Menon also identified an actuarial model that looks at risk probability based on identified risk factors that can be weighed and balanced and used to predict outcomes. This approach would consider variables that are risk indicators established through statistical analysis or possibly professional wisdom. The third model that Menon identifies is structured professional judgement; this combines many of the elements of the first two but proposes a more dynamic process of information gathering, risk assessing, planning and reviewing which is individualised based on the patient's story, current situation and desired outcomes.

Glover-Thomas (2011) undertook a study of the decision-making of various professionals involved in mental health decision-making. In the Glover-Thomas (2011) study, psychiatrists identified what they called dynamic, static, acute, and chronic risks. Static risks were historical events in the person's risk history. They considered dynamic risks, as risks that may or may not be present and can change over time, such as substance misuse, housing situation, existence, or lack of support networks.

Glover-Thomas (2011) observed that practitioners believed that part of their skill set, when assessing risk in mental health work, was about comparing current cases with cases they had dealt with previously and using binding precedent as a way of estimating risk. This potentially includes elements of actuarial decision-making, as the AMHP would be using their professional wisdom to identify the presence of risk indicators based on their predetermined perceptions of what would indicate risk. These perceptions or precedents that mental health professionals are working to, are frameworks partly based on the practitioners' past experiences of working with similar situations.

Glover-Thomas (2011) describes this as a Yardstick model, in which the practitioners consider all the factors of the case and gauge the risk based on how far the person deviates from their view of fixed norms. Glover-Thomas (2011) considers the possibility that this pragmatic, rather than formal legal decision-making process, opens up the possibility of the assessors pre-determining the outcome of an assessment based on the person's previous history. This is particularly the case, if they have had "long and tempestuous psychiatric history", something which Glover-Thomas (2011) believed carried the risk of practitioners imposing their own "subjective moral codes" (p. 599).

In a study of the decisions made by ten AMHPs, Buckland (2014) identified frameworks that they used to conceptualise and interpret mental health and possible pathways of treatment and care. These frameworks included the power and responsibility embedded in their role, shifting attitudes as they became AMHPs and accepted more medicalised frameworks of understanding. This was sometimes described by the AMHP as instinctive or intuitive decision-making based on how they would feel afterwards if they did not do anything. Buckland describes the discomfort that AMHPs expressed but the reality was that their autonomy and independence was limited by their professional accountability.

### *Summary*

There appears to be similarity in the element's professionals consider when assessing a situation. Firstly, the creation of a framework of understanding/problem setting, and then the consideration or application of additional elements as the assessment progresses, which may or may not alter their original hypothesis. There is also evidence from the research that social workers and other mental

health professionals use a multi-layered approach, beginning with the consideration of historical risk factors that are not specific to the present situation or templates not necessarily based on the individual being assessed. These frameworks are then developed by considering factors that are current to the individual and their situation. The next section looks at the process of decision-making in social work and healthcare more generally.

## **2.8 Weighing and Balancing Decisions**

In this section, I look at the structure of decision-making by social workers and other healthcare professionals and how they interact with the legislative framework of mental health/capacity legislation utilising and applying concepts of risk and autonomy.

The interaction between different factors such as the law, social workers' experience and other situational factors was researched by MacDonald (2010). MacDonald (2010) interviewed fourteen social workers to investigate the relationship between the principles and legalities of the MCA and its application in practice. One of the key factors identified was that of experience and, although most social workers stated that they welcomed the opportunity to include the person's capacity to make a decision in their assessment, the less experienced social workers put a greater emphasis on the person's diagnosis when assessing than the more experienced workers. In other words, they recognised the importance of respecting the autonomy of the individual but still gave a greater weighting to static factors such as diagnosis and risks perceived to be associated with the diagnosis.

The MCA test of capacity does require the assessor to identify a disturbance of the mind or brain to engage the MCA, but it does not require the assessor to consider the nature/diagnosis of the person's mental disorder in the way the MHA does. The MCA test of capacity is a functional not a diagnostic assessment and, therefore, regardless of the person's specific diagnosis or disturbance, everyone should be presumed to have capacity unless assessed as otherwise, and the making of an unwise decision does not automatically indicate a lack of decision-making capacity. MacDonald questioned whether the tendency to focus on diagnosis, when undertaking MCA assessments, arises from over-reliance on medical models of understanding or, pressure arising from inter agency working, which

may impact less experienced workers more, or from other factors. This could be considered as an example of negative or bias framing (O'Connell, 2013) if there is evidence that diagnosis is being used as a presumptive way in assessing someone's ability to make a decision.

MacDonald (2010) found that social workers understood the separation of assessing capacity from making best interest decisions in theory, but in practice the two tended to be conflated (MacDonald, 2010). There are key principles of the MCA that help to illustrate this. The first is presumption of capacity. The person should be presumed to have capacity on a specific question unless they are assessed to be otherwise. The assessment is decision specific, in other words the social worker is not assessing global capacity but decisional capacity in relation to a specific subject or question, and the assessment is also time specific as a person's loss of capacity may be temporary. Secondly, the person has the right to make unwise decisions. It is not the quality of the decision that is the focus of the assessment, it is the person's ability to understand the question being asked, their capacity to retain, weigh up and use that information and the ability to communicate their decision. Only when an assessment of capacity has taken place and the person is assessed as not having capacity can the principle of deciding about the person's best interest be considered. To clarify, if the person has capacity, then no other action can be taken using the authority of the MCA.

MacDonald (2010) highlighted that, at the point of assessment, social workers were conflating the question of capacity with the question of best interest, so even when the person was assessed as having capacity the social worker was still inclined towards making a best interest intervention. Another factor in assessing capacity was the level of understanding the social worker expected from the service user, linked to the extent of perceived risk to the individual arising from the decision. In other words, the greater the risk, the harder the service user had to work to convince the social worker they had capacity (MacDonald, 2010). This could be due to the complexity of information required as the level of risk increases, although MacDonald does not comment on this. It could also be risk aversion arising from possible negative consequences for the practitioner, which has also been identified in other areas of practice (Kemshall & Pritchard, 1997; O'Connell, 2011) and is cited as a contributory factor in oppressive substitute decision-making.

Glover-Thomas (2011) found that practitioners did acknowledge how the perception of others impacts on the decision-making process, particularly regarding the taking of positive risks. Positive risk-taking occurs when the practitioner acknowledges that possible harm is occurring but assesses this is likely

to be short term harm. In the longer term, they perceive that a detention would do more harm to the person than good. However, they may still detain the person because of the outside possibility of serious harm occurring which might call into question the assessor's judgement. Glover-Thomas (2011) states that practitioner's concept of risk was pre-emptive, based on the possibility of something negative happening if nothing was done to prevent it.

Glover-Thomas (2011) found that the language of risk was pervasive and concluded that it appeared that the consideration of risk had supplanted other concepts such as need or welfare provision. This increases the likelihood of adopting an outcome-based model of decision-making in which the practitioner starts from a desired outcome and works backwards. In other words, without reference to an objective evidence-based decision-making framework, you can create a narrative allowing you to do what you think is best for the person in each situation by weighting risk factors accordingly to justify a predetermined outcome. This view is consistent with Peay's (2003) findings, where assessors took a mix and match approach including retrospectively selecting factors to justify their decision.

MacDonald (2010) described the social work decisions analysed as aggregated decision-making. Rather than making decisions that were time and situation specific, the social workers aggregated the information that they had about the service user, drawing on knowledge they had about the person's previous behaviour. Social workers were also influenced by pressures from other agencies, for example the powers of eviction held by a housing agency in relation to a specific case. Once variables such as circumstances of the case, working environment, experience and knowledge had been factored in, MacDonald (2010), identified three broad types of decision-makers: legalistic, actuarial and rights based. The legalistic or legal positivist decision-makers are those who view their decision-making as a "morally neutral system of commands and duties" (MacDonald, 2010 p. 1236). These social workers tend to be more concerned about the procedure of decision-making rather than outcome, regardless of whether the outcome is positive or negative. MacDonald (2010) observed that these practitioners tended to see themselves as legal advisors within their teams and made regular reference to the legislation, codes of practice and case law. Interestingly, MacDonald (2010) observed that a high proportion of these social workers were AMHPs.

The second group of decision-makers identified were actuarial decision-makers, this was the group identified as those most likely to conflate decisions about capacity with decisions about a person's

best interests. They were also likely to take a persuasive approach with the person they were assessing rather than following a procedure of assessing capacity as separate from the outcome. In the same way that actuarial risk assessors calculate possible outcomes in business and investment, this group assess capacity and the possible impact of the decision. These social workers use their knowledge of the overall history and current situation to predict possible outcomes, using concepts such as probability. By focusing on the positive and negative consequences of the person's decision, they were allowed into their assessment of capacity, factors such as the possibility of an adverse outcome which may reflect negatively on them or their organisation. In these circumstances, the duty of care role by the social worker and agency could override the person's right to make unwise decisions, even though this right is protected within the MCA.

The third group of decision-makers are described as rights based. MacDonald (2010) describes these social workers as taking an "equality of citizenship approach" (MacDonald, 2010, p. 1239), in which they use the legal test of capacity to support a person's decision to maintain their chosen lifestyle. This group of practitioners tended to be less enmeshed with other groups of professionals and approached their role more independently. Their approach is identified as person centred, and this applies even in cases in which an assessment is made that the person does not have capacity. These practitioners were said to be critical of the other methods of decision-making, particularly actuarial decision-making, which they felt relied too heavily on stereotypes and the belief that undesirable behaviour was evidence of a lack of capacity. MacDonald (2010) found that a rights-based approach was more likely to consider psychosocial/spiritual needs as well as physical needs. MacDonald (2010) concluded that, although most social workers welcomed the MCA and a functional rather than diagnostic approach to capacity, they still had trouble in separating assessment of capacity from concepts such as duty of care, limited choice due to limited resources, organisational considerations and pressures arising from multi-agency working. Although MacDonald (2010) uses different terminology, there are broad similarities with the three groups of decision-makers identified by Menon (2013) above.

Peay (2003) researched the decision-making of both ASWs and psychiatrists. Peay's research included a mixture of section 12 approved psychiatrists with specialist training in mental health and the law, non-section 12 psychiatrists and ASWs. There were 106 participants in total and they were asked to comment singularly or in pairs on three sets of fictitious vignettes. Peay (2003) found there were differences between the decision-making of ASWs and psychiatrists but did identify similar categories

of decision-makers across professions. These included clinical decision-makers who are driven by what they believe is in the person's best interest and look to using the Mental Health Act 1983 to facilitate these predetermined best interest decisions. Peay found them to be less dogmatic in their views and open to negotiation, including trying to avoid negative labelling. In addition, Peay identified legal decision-makers who are guided primarily by the legislation and what the MHA legal powers allowed for, seeing the legislation as a legal safeguard. The third group were ethical decision-makers who are driven by the issue of capacity and would only consider best interest decisions or interventions against the person's will if the person lacked capacity.

In this study of decision-making prior to the 2007 amendment, Peay (2003) found there was variation in decision-making both within professional groups and inter professionally, although joint decision-making appeared to reduce variance and the introduction of different professional perspectives did alter the outcome of the decision. Multi-disciplinary decision-making was identified as producing a more consistent approach. Peay observed that different professionals influenced the process disproportionately, dependant on the decision to be made i.e. an ASW responds to the request for a formal assessment and makes the decision independently as to whether or not an assessment will take place. The ASW also has the final decision with regard to an application for detention being made. Similarly, medical professionals have their specific area of influence over the decision process regarding the making of a medical recommendation for detention or renewing someone's detention, this was seen as reflective of their area of professional responsibility embedded in the MHA.

Though not specifically about decision-making in relation to mental illness, the findings from Osmo and Landau's research (2010) propose a methodological approach by social workers that could ensure more objective decision-making. Osmo and Landau (2010) argued that social workers need to be aware of the factors that affect their decision-making and be willing to open their decision-making to scrutiny, by both external and internal reflection. The factors they think that social workers need to be explicit about are personal and professional ideas, and the values, concepts and assumptions that they use as a guide to their practice. Although not arguing that social workers can ever be entirely objective in their decision-making, Osmo and Landau (2010) suggest that practice would be less oppressive if social workers reflected upon and made explicit personal and professional ideas and the values and assumptions that they use as a guide to their practice. This theme is supported in the research of Gray and Gibbons (2007), who contend that, because social work is an art practiced in the

social world, ethical conventions and guidelines are important and useful but critical reflective practice is also an essential part of ethical decision-making.

Osmo and Landau (2010) acknowledge that there is an inevitable gap between what they describe as “technically possible” and “morally desirable” (Osmo and Landau, 2001 p. 484). Unlike MacDonald (2010), Osmo and Landau (2010) do not distinguish between types of decision-makers, but instead identify some key approaches to social work decisions. These are described as the rules principle approach which incorporates case law, rules and principles of practice. Secondly, the character/structure approach is based on the person’s beliefs, principles and ideals, in other words how the social worker sees themselves morally. And thirdly, the background beliefs approach which is influenced by a sense of purpose, or the social worker’s sense of the deeper meaning behind decision-making in relation to what they are seeking to achieve. Osmo and Landau acknowledge that there are decisions that must be made and implemented quickly and describe this decision-making as automatic or intuitive which they concur may be “useful” (p. 485), when time is critical, but it is not ethically desirable. For decisions to be ethically defended, Osmo and Landau (2010) suggest they need to be critically evaluated. This process of explicit argumentation involves the use of empirical facts, experience and prior knowledge, as well as the application of ethical principles and rules. This explicit rather than implicit form of decision-making should make the process transparent to the individual, as well as resulting in decisions that are less arbitrary. An appropriate theoretical framework for explicit argumentation is one developed by Toulmin (1958), cited in Osmo and Landau, (2010). There are six component parts to this process:

1. a statement/claim or conclusion
2. evidence or data that supports the claim
3. make connections/inferences from the evidence
4. expression of confidence in the evidence
5. explore the counter evidence and limitations of the theory
6. justify the evidence presented

Although developed in the 1950s, this structured process of decision-making enabled the social workers who took part in their research to take a structured approach to reflective practice and be able to understand their own decision-making, and defend it externally, in an explicit way. In a similar way, Denvall (2008) concludes that social work has much to learn from “classical organization theory”

(p. 39), in the way decisions are made, and that evidence-based practice is a strong factor in driving this process through.

### *Summary*

There does appear to be some consistency across the literature that suggests that, although not always conscious of it, professionals including social workers do use similar processes to gather information and analyse that information prior to acting on a decision. In the next section, I look at some of the evidence on the outcomes of Approved Social Workers (the role which preceded the establishment of the Approved Mental Health Practitioner) and then move on to discuss AMHP decision-making and the possible factors that influence these.

## **2.9 Decision making by Approved Social Workers**

The AMHP role was created with the 2007 amendment to the MHA, prior to this a very similar role was undertaken by ASWs who were exclusively social workers. Sheppard (1990) published research into the decision making of ASWs. Nine ASWs had taken part in the research and had been asked about actual considerations of MHAs they had done over a twelve-month period. A total of 120 considerations had taken place over this period, the evidence gathering took the form of semi structured interviews in which the ASW was asked four core questions about their case. The questions were: What were the social circumstances they considered? What were the problems regarding health, safety and the protection of others? Why had the ASW chosen a particular route i.e. detention or informal admission and were there any disagreements with other professionals?

Sheppard (1990) viewed the role of ASW as a gatekeeper; they were gatekeepers in relation to admission to hospital in which they had the power to arrange or refuse admission. This power also impacted on the person's access to other resources as someone who did or did not have a mental illness label, which could have positive or negative connotations for the person.

Sheppard (1990) viewed ASW work as dealing with a social problem because whatever the cause of a person's symptoms it is the fact that these symptoms can be socially problematic that brings the individual to the attention of the state. The ASW role and mental health law derives from the decision by the State that mental illness is a social problem and therefore needs legislation to regulate its impact on the individual and society. These welfare roles such as ASW are delegated roles that the State uses to manage social problems within the parameters of the dominant ideas that define mental illness as personal and therefore, the person must be susceptible to personal solutions.

Sheppard (1990) argued that, although generally social workers derive their authority from the State via their employer (usually the local authority), it is different for the ASW as they derive their authority under the MHA directly from the law, which in theory should lead to greater empowerment for the ASW. Sheppard describes mental health law as “open texture” law which is uncertain and open to interpretation. This authority derived from the legislation and lack of prescriptive guidance, Sheppard argued, meant that the ASW was empowered but also meant that the decisions they made could be arbitrary and vary in content depending upon who was applying them.

Sheppard (1990) also argued that in the absence of specific guidance, the ASW would default to the criteria of the MHA and consider risk to health, safety and the protection of others as their starting point. Sheppard considered risk as being a fluid concept in many ways and proposed that it should be broken down as a concept. The way Sheppard achieved this was to differentiate between hazards, danger and harm. The example used is that banana skins can be hazardous; we are in danger of slipping on them if there is one on the pavement, and if we do fall on them, we may experience harm. This analogy was used as a way of analysing ASW decisions: could they be broken down to describe hazards, identifying when there were dangers associated with the hazard and if there were, what harm could be reliably predicted.

Sheppard (1990) believed that lack of clarity on the differences between hazards and dangers led to admissions by default as the ASW did not identify the nature of the hazard, the degree of the danger or its imminence. He went as far as to suggest the ASW was stepping outside the ‘health, safety and protection of others’ criteria by focusing on mental illness as a criterion in itself, especially when there had been a previous MHA detention. Sheppard acknowledged that his opinion was at odds with others who view mental illness as part of the health criteria that may qualify them to be detained under the MHA but took the view that both the nature and/or degree of the mental illness required separate risk considerations as per the health, safety and protection of others.

Assessing risk to the person’s health, safety and protection of others is “a matter of great complexity” (Sheppard, 1990, page 67) and is not simply a case of applying objective or easily understood principles which can be applied in a uniform manner. Assessing individuals is not the same as assessing general populations on the grounds of actuarial factors and there are no precise figures on which ASWs could make predictions of probability.

A range of elements was identified within the health and safety protection criteria, for example the protection of others could include direct physical harm, freedom from harassment and stress arising from being a person’s carer. And as mentioned previously this left the ASW the scope to include in

these considerations what Sheppard describes as a mental health orientation in other words the presumption of risk based on the presence of mental illness alone. This was interpreted as the ASWs being too uncritical of medical interpretations of mental illness and that there was a lack of sufficient emphasis on social circumstances. This critical approach did not necessarily involve the ASW rejecting the psychiatrists diagnosis of mental illness Sheppard states that the ASW can stay agnostic on this question but they should take a position on the possibility that detention was because mental illness was framed as part of the residual rule--breaking of societal norms.

Sheppard's solution to the ambiguity and lack of clarity was to recommend greater structure to ASW decision-making, this included a more explicit presentation of the ASWs rationale for making a decision. Sheppard attempted to show how this could be done by presenting four categories of decision to detain with increasing levels of concern about how the conclusion to detain was arrived at. Stage one was demonstrated danger, where harm had already occurred, and the detention took place to prevent further harm. Stage two was probable or latent danger, here the danger is identified and linked to a hazard, although harm had not yet occurred. The third stage was uncertain but dangerous, hazards are identified but it is not entirely clear what the harm would be. Stage four was uncertain and unclear, where no harm had occurred and no clear hazards or dangers have been identified, Sheppard placed the mental health orientation in this category.

Following the original research Sheppard (1993) developed an assessment tool for ASWs designed to promote more consistent decision-making and clarity about how decisions were made. Sheppard named this the Compulsory Admissions Assessment Schedule. Sheppard (1993) published research carried into the effectiveness of this assessment tool. A group of ASWs were trained in the use of the tool and 71 assessments were undertaken using the structured assessment. Sheppard (1993) reported that ASWs found the tool useful in 50 out of 70 cases and reported that in the other 20 cases the grounds for detention were so obvious they had not found it necessary to apply it. Sheppard claimed that the most significant finding was that it could be clearly identified how the ASWs decided between detention or not. It was also claimed that it made the retrospective scrutiny of decision making easier as the ASW was asked to rate the hazards and dangers when considering the criteria for detention. Sheppard acknowledged that this only applied to a relatively small number of assessments and it was not possible to separate the training the ASWs had received from the actual filling in the assessment tool as the prime causative factor.

Quirk et al. (2003) also looked specifically at the decision making of ASWs, focusing on the non-clinical/legal aspects. The study was undertaken using participant observations of MHAAs, and informal and in-depth interviews with ASWs.

The main findings of the research was that factors leading to formal detention included lack of available time on the part of the ASW, lack of less restrictive alternatives, the team structure and the operational culture of the team that the ASW belonged to. These were compounded by the prevailing climate around risk and mental health, the service users' family circumstances and personal characteristics.

The events leading to assessment that meant detention became more likely were the perceptions of the person's illness by the people around them and their levels of tolerance towards the person's presentation. The context was also important i.e. someone in a supported environment like a care home with support, was less likely to be formally assessed than someone living at home. Other subjective factors also included the pressure to assess from the referrers, local admissions policies and bed availability. The service users' resistance to receiving support or agreement to informal admission were also factors.

The structure of the team the ASW belonged to also impacted on the decision; some teams were described as supportive environments in which the ASW had the opportunity to discuss their assessments and received peer support regarding risk taking. ASWs in other teams reported having large caseloads and regular allocation of new cases which made their MHA work an additional pressure.

The relationship with service users was also identified as a factor, as some teams knew their service users well and tended to have higher risk thresholds. It was also reported that ASWs who knew the culture of the inpatient wards well were more reluctant to detain as they felt it would have a negative impact on the person being detained. This was also evident with some service users who knew the culture on the wards and would refuse informal admission, making detention more likely. There was also evidence that the ASWs calibrated their decisions about detention based on how they perceived the service user would cope on an inpatient ward; these decisions were identified as also being influenced by the service user's social class and previous history of admissions.

### *Summary*

The role of the ASW has many similarities with the AMHP, although changes in the professionals eligible to undertake the role, changes in the legislation, social policy and the demographics of the United Kingdom in the 21<sup>st</sup> century mean that although similarities with AMHP practice can be

identified, direct comparisons in terms of the role and its context cannot be made. The next section will start to examine the contemporary role and circumstances within which it operates.

## **2.10 Professional Roles and the AMHP**

There are some identified patterns in the quantitative research below that suggests that there are changing patterns of outcomes from MHAAs over recent years including a rise in compulsory detention.

In 2012/13 there were over 50,000 uses of the Mental Health Act to detain patients in hospital for assessment or treatment, not counting the use of short-term holding powers? This is the highest number of uses of the Act ever recorded (CQC, 2014, p. 12).

As mentioned previously, there are multiple variables that can possibly affect outcomes such as resources, legal judgements, local protocols and the individual decision-making of the AMHP. The CoP/MHA is specific about the expectation that the AMHP considers alternatives to detention and the social factors relevant to the situation. More specifically:

Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding Principle. (Code of Practice, 2015) para 14.52

The amendment to the MHA brought about the transition of the ASW to the new role of the AMHP. At the time of the change, there was concern that the new role incorporating a wider range of mental health professionals may lead to a diluting of the social critique of mental health within MHAAs

(Hatfield, 2008). Hatfield (2008) contended that social work brought to the role a unique understanding, partly because social work training had a social sciences basis to it that took account of concepts such as relativism and social construction. Hatfield (2008) believes this is also supported by a greater understanding of the social context of mental health, influenced by issues such as housing, unemployment, poverty and life events. The training for the ASW role sought to ensure that social workers were better equipped to work with concepts of race, language and culture, or use cultural competence. The notion here being an understanding of culture is central to interpreting an individual's experience of mental distress (Hatfield, 2008).

Much of the literature written in the first few years after the 2007 amendment of the MHA 83 (Campbell, 2010; Furminger and Webber 2009; Hatfield, 2008) comments on the new role of the AMHP and the potential challenges it presented, but they did not overtly discuss the actual outcome of this change. There are two possible reasons for this; a) the research they undertook was longitudinal and preceded the implementation of the MHA amendment of 2007, and b) the literature they reviewed also predated the changes. There is still value in including this research within this review however, as the similarities in roles for ASWs and AMHPs and similarities in the MHA itself, pre and post 2007, are such that significant comparisons can be drawn. The significant change with the advent of the AMHP role was the incorporation of mental health professionals other than social workers, which needs to be kept in mind when considering variables relating to possible explanations.

Hall (2017) undertook a comparative study of decision-making of ASWs and Home-Based Treatment (HBT) professionals when considering eligibility or suitability for HBT. The study identified 54 cases where HBT had been considered and sampled nine of these using semi-structured interviews with the participants involved. Hall identified a difference of approach between ASWs and other mental health professionals suggesting that the ASW role may have brought with it a difference of perspective irrespective of prior professional training. (Although published in 2017, Hall's study was originally undertaken in 2008 and therefore refers to ASWs).

Hall (2017) describes the unique attributes required for ASW work and identifies that the ASW was required to have significant skills and knowledge of mental health work, be able to exercise independent judgement and be personally accountable for their own practice. In addition, they were required to also have skills in engagement and the ability to explore the social context of the situation

in which the assessment is taking place. Hall identifies the centrality of the social model in ensuring that the legal requirement of the ASW to consider all the circumstances of the situation is correctly applied. Therefore, regardless of prior professional training, the MHA imposed on the ASW and the ASW role the necessity to at least consider non-medical factors and social explanations for the situation they are presented with.

Hall (2017) found that the differences between ASWs and their colleagues in Home Based Treatment (HBT) was that ASWs explored the service user's world and framed their problems in terms of social crisis, whereas HBT professionals tended to focus on individual pathologies and risk. ASWs focused more on causation, whereas HBT professionals tended to be more focused on diagnosis. Hall also found that ASWs tended to be more descriptive of the person and their circumstances rather than focusing on the person's diagnostic history while HBT diagnostic led risk assessments seemed to address more generalised rather than individualised risk. This was especially the case when the assessment involved someone with no previous diagnostic history.

A study of 17 mental health social workers by Morriss (2016) describes how mental health social workers found it difficult to identify their role within integrated mental health services. Morriss described mental health social work as invisible, this was attributed to the structure of the service which meant that social workers felt dislocated from their employing local authority and lacking in social work leadership. Social workers described the difficulties they experienced maintaining their professional identities as opposed to their other mental health colleagues in other professions. This blurring of roles due to social workers operating in integrated mental health services under health management dovetails with the issues raised by Hatfield (2008) regarding the dilution of the social work perspective in the transition from ASW to AMHP.

More recently, research evidence has begun to emerge on the possible impact of the inclusion of professionals other than social workers into the AMHP role, which was previously a role exclusive to social workers who were ASWs. The impact of this change was researched by Stone (2018), who did an exploratory study of 20 AMHPs, half of whom were from nursing backgrounds and the other half social workers. The study explored their decision-making relating to the management and assessment of risk using an experimental vignette. Stone concluded that there were no discernible differences and there was no evidence to suggest that AMHPs who were social workers used criteria that was

significantly different from non-social workers when deciding whether to detain someone using the MHA. This also applied to how they considered risk and their application of social models of mental health and illness

The evidence suggested that all AMHPs were aware of the requirement to consider least restrictive alternatives and there was a consistency in the belief that to make Section 2 rather than Section 3 application was viewed as a less restrictive alternative. Rather than being based on professional background, the evidence was that these considerations were individually framed, with AMHPs attaching their own meaning to different risk factors based on the AMHPs experience and personal risk thresholds, which also included the beliefs about personal accountability for adverse outcomes.

At first the findings of Stone (2018) would appear to contradict the work of Hall (2017). Stone's research focuses on the decision-making of AMHPs who have different professional backgrounds, but who are now undertaking assessments within the context of the role of an AMHP. Stone's findings suggest there is no significant difference between the decisions they make once they become AMHPs. Hall's study focused on professionals assessing risk in mental health without having the shared qualification of ASW or AMHP. This suggests the possibility that the AMHP role brings with it a unique approach to decision-making, regardless of prior professional roles the AMHP holds. There may be differences between social workers and other mental health professionals in their practice and beliefs, however there may be no difference between the practice and beliefs of social workers and non-social workers who are AMHPs. What may be significant is that those from different professions develop a separate and shared AMHP identity regardless of their original professional training.

In a study of 10 AMHPs with social work backgrounds Buckland (2014) found that there was a shift in perspective once they had qualified as an AMHP. Buckland describes this as a shift from a civil rights perspective which saw detention as problematic to a perspective that focused on the right to treatment. AMHPs recognised the shift they had made towards a more medicalised perspective and justified this on the basis that they needed to do something for people in distress even if the choices were limited.

The findings of Watson (2016) who interviewed 12 AMHPs about the reason they decided to undertake the training suggests that the perceived independence of the role and the ability to independently influence decisions was a motivating factor. The participants who were a mixture of social workers and nurses also believed that the role gave them more scope to introduce a social perspective which they found difficult in their other professional roles. There were no differences identified between professions other than AMHP training being an expectation for social workers which was not the case for nurses.

In a study of social workers and nurses undertaking the AMHP training, Bressington, Wells, and Graham (2011) researched the impact previous professional roles had on the trainees' understanding of the AMHP role. The study used concept maps and interviews with five nurses and four social workers. The participants were interviewed at three stages, prior to the training, after the teaching block and at the end of the placement. Bressington et al. (2011) noted the concern previously expressed, that including non-social workers in the AMHP role could lead to the diminution of the independence of the AMHP and the unique contribution they bring regarding social perspectives of mental illness. The result of their study suggested that, prior to undertaking AMHP training, social workers had a better understanding of the AMHP role than nurses. This was believed to be due to social work practice being closer to AMHP practice than nursing. This was also believed to be possibly because social workers had spent more time shadowing AMHPs and there was a greater expectation that, as social workers in mental health, they would at some point undertake the AMHP training.

When they were interviewed again following their teaching block, analysis of the impact of taught modules suggested that there was minimal change in understanding and that any changes were essentially surface learning. Analysis of the interviews at the end of the practice placement element of the course were described as “remarkably different” (p. 569) and that, on the completion of the practice placement training, it was no longer the case that non- social workers expressed a different understanding of the AMHP role. It was concluded that, following AMHP training, both professions had a shared understanding of what the AMHP role entailed.

Another insight into how the process of integration and assimilation takes place was identified by Bressington et al. (2011), which described how the nurse participants expressed the belief that, although they felt there was no difference in their practice, this was not the perception of others.

Some of the nurses described how other colleagues would assume they were social workers, which sometimes led them to hide their identity as nurse AMHP trainees. This assimilation of social workers and other healthcare professionals into the role of AMHP may therefore be more challenging for some professionals than others.

Morriss (2015), in a study of social worker AMHPs based in mental health trusts, explored how their professional identity was accomplished and maintained. The study involved the use of semi-structured interviews and a discussion group involving five participants. One of the ways this is done is described as the telling of “Atrocity Stories” (p. 1072) as a way of creating and maintaining group identity. Atrocity Stories are told by the AMHPs as eyewitness stories with a dramatic quality, and which describe the behaviour of professionals from other groups and is used to emphasise the different approaches that other professionals take to a given situation. Often these stories are told with an element of criticism of the actions of other professionals to emphasise the uniqueness of the perceived difference in perspective from the AMHP’s point of view. Another element of this approach is the way in which professionals of the same background in group situations are observed co-narrating these atrocity stories as part of establishing a group identity. The AMHPs in the study were all social workers located in health community teams, where professional boundaries with other mental health professionals may not have been entirely clear. The use of Atrocity Stories is potentially a way of maintaining professional identity in an environment where one group of professionals, in this case social workers, may feel less valued or threatened by the professional status of others.

Morriss (2015) identified that the telling of Atrocity Stories by the participants was a way of establishing occupational differences in a boundaried group. Part of this process included the use of “contrastive rhetoric” (p. 1074) which juxtaposes the perspective of one profession to another, aligning the recipients of the story with their perspective and defining them as having a collective experience different to others, therefore underlining their collective identity. Morriss (2015) concluded that this was not simply a process of one participant driving the thinking of others, but a process of co-narration and confirmation of common experience which strengthens notions and feelings of cohesion. Expressing negative shared perceptions of others created the feeling of a positive shared experience by the group. The unfinished sentences completed by a colleague increased the sense of shared understanding and the feeling that only members of this group share those experiences. The term “They” was often used to describe other professionals, a process Morriss believed was designed to ascribe characteristics to a group rather than to an individual. AMHPs

described health professionals' practice as focusing on numbers (targets) and categories of diagnosis, rather than focusing on the needs of the service user.

Morriss (2015) identified that part of the process of maintaining group identity also included collective humour which highlighted shared negative experiences of their professional group as opposed to others. This was reinforced by laughter at certain points in the discussion. Morriss (2015) also believes that, as an insider researcher, they had the ability to co-narrate stories with group members, something that would not be possible by an outside researcher who would be more likely to take the approach of a naïve interrogator. Morriss's findings are significant in understanding how group thinking can develop in focus group interviews and provides insight into how groups of professionals develop distinct cultures in practice or generate the self-belief that they are working to professional cultures that are different from others.

The findings of Stone (2018), who identified no difference in the decision-making of social work and non-social work AMHPs, indicates the possibility that AMHPs are a distinct group. This supports the research by Bressington et al. (2011) which showed that being involved in AMHP training and practice possibly creates a role separate to other mental health professionals while still maintaining historic links to social work values and beliefs previously embedded in the ASW role. The research of Morriss (2015) indicates that being part of a practice culture of AMHPs is a key factor in the development of practice knowledge or received practice wisdom and this in turn, shapes decision-making.

### *Summary*

It is not the intention of this study to examine the difference in the decision-making of social worker AMHPs and non-social work AMHPs. The different perspectives offered here are significant in the development of an understanding of how AMHPs make decisions. This evidence suggests that it is not necessarily the professional background that is the key, although there is evidence that the social work perspective continues to dominate the AMHP role. It is more supportive of the view that AMHPs are a distinctive professional group in themselves, whose identity and culture are maintained through the training and a shared view of their practice as distinct from others.

## **2.11 Risk and Mental Health Assessment**

The concern that primarily drives the need for an assessment or compulsory detention identified by a number of authors is risk, their research and perspectives on this will be discussed in the next section.

Peay (2003) in a study of decision-making by 40 ASWs and 52 Psychiatrists identified risk as the key determinant in their decision-making. In line with the requirements of the MHA these risks included the person's health, safety or the protection of others. In Peay's study, practitioners concluded that it was justified to detain someone on the grounds of health alone (this includes both physical and mental health), even when there were no other apparent risks to others arising from this risk. This was expressed as a wish to reverse current decline and to prevent further problems in the future if current health concerns were not addressed. Harm to self was considered and indirect harm to them through retaliatory acts by others, usually relating to the way in which people may react to their presentation of mental illness.

Peay (2003) compared the risk of harm that practitioners described with the reasonable fortitude legal test used in personal injury law. This test considers the level of actual harm that could be reasonably anticipated from a person's actions. In other words, the level of accountability by a perpetrator of a violent/aggressive act is based on what level of harm they could reasonably foresee when attacking or assaulting another person. Peay (2003) found that, in mental health, the reasonable fortitude test was not clearly apparent when the AMHP considered what level of harm would occur to that person or others if no action was taken by mental health professionals to manage this perceived risk.

Risks to others included direct physical harm arising from the person's beliefs, psychological harm arising from the impact of the person's presentation on others and harm that may occur during a retaliatory confrontation. In weighing up these considerations, practitioners gave the greatest weight to the consideration of harm to others, although there was no clear consideration of a threshold of the likelihood of harm actually occurring. There was also evidence that, once the possibility of harm to others was established, the threshold for detention was often immediately met. This sometimes included what Peay (2003) describes as factual errors arising from erroneous recall, in other words the practitioners were considering factors, believed to be in the person's risk history that had not actually occurred.

Glover-Thomas (2011) in a study of 19 mental health practitioners from different professional backgrounds, including AMHPs found that the overwhelming view of practitioners undertaking assessments was that past behaviour was the main predictor of current risk, although contextual factors such as substance misuse, current diagnosis, and personality are also considered. The psychiatrists focused primarily on clinical history as a risk predictor, but this approach was also adopted by the AMHPs and was a significant influence. It was also significant that there was a greater likelihood that people would be re-engaged with services if they were previously known as having a psychiatric history

Glover-Thomas (2011) also identified the belief amongst mental health practitioners that the 2007 amendments to the MHA had introduced a broader definition of risk, even though they could not state where this was written in the MHA. Glover-Thomas (2011) describes this as an erroneous belief and, although in practice additional risk concepts were being considered, there were no additions to the detention criteria in the Amended MHA itself. This was attributed to public anxieties and the risk agenda that dominated the period of reform, including a general view that the key focus of the 2007 amendment to the MHA was the question of risk posed by the patient. Risk terminology was commonly used by practitioners, although they did not provide a clear definition of what risk is or how it is defined (Glover-Thomas, 2011). Participants offered what were described as circular explanations, or the risk is risk paradox; meaning that practitioners may not have been able to define risk in the abstract, but they believed they would know it when they came across it. Glover-Thomas describes the approach practitioners took as a "risk recipe model" (p. 595) where the practitioner selects various risk ingredients, the most important being the patient's clinical history with the additional consideration of current clinical factors and current social factors.

Glover-Thomas acknowledges that the assessment of risk is, by necessity, a subjective process which is therefore more likely to be inaccurate and inconsistent and believes that this can be partly attributed to the non-prescriptive guidance in policy, the MHA and its code of practice. The criteria for risk, as defined by the MHA, does not prescribe a threshold required to justify detention and there is nothing in the legislation or case law that defines what factors or accumulation of factors meet the criteria.

“Risk is an open-ended construct for decision-makers to assess and interpret in accordance with their professional judgement and experience” (Glover-Thomas, 2011, p. 584).

A broad definition of risk may therefore be unavoidable which means that risk has a more pervasive influence because of the lack of a clear definition and method of weighing this. Glover-Thomas (2011) also states the belief that the inconsistent definitions of risk used by the practitioner reflects the lack of clear definitions of risk in local and national guidance. The process was essentially a hermeneutic or interpretive exercise which was then transposed onto a legal process. Participants themselves acknowledged that they did not have a comprehensive definition of risk. This view was present across all the professional groups and possibly due to the influence of joint working and decision-making which had created a blurring of traditional boundaries.

Coffey et al. (2017) identified that risk assessment by mental health practitioners is often experienced by those being assessed as an external concern, something that is driven by the worker’s concern rather than their own. Service users described themselves as being the passive recipients of risk assessments and believed that practitioners were primarily concerned about deflecting responsibility and avoiding blame. Mental health practitioners accepted that they did not involve service users to the extent that they should do and also confirmed the belief that they tended to err on the side of caution. Service users’ involvement in risk assessments was often at the level of asking them to answer pre-determined questions, rather than being an involved process or dynamic process. This left the service users feeling they had been negatively assessed and while they described wanting to be safe, they also felt that the restrictions on their choice and liberty, because of being labelled risky, limited the likelihood of recovery and continued liberty.

Coffey et al. (2017) describe practitioner risk assessment as a form of moral work which gives them legitimacy when making decisions about others, although this can lead to practitioners using accepted fictions based on the practitioner’s view of what is risky. As there is no legal definition of thresholds, accepted fictions cannot be challenged as they are based on the notion that risk is ambiguous. Outcomes are uncertain even though there are significant outcomes (harm or detention). These accepted fictions take on the air of objectivity by the worker, despite the lack of scientific evidence. Neo liberal notions of self-reliance and blame were identified as the ideological framework from which these notions have emerged, such as service users should take on responsibility for their own recovery

and, at the same time, accept the blame when things go wrong. Coffey et al. found that, despite the emphasis on service users taking responsibility, there was little evidence of the service user being central to their own assessment of risk. Nevertheless, workers, service users and families generally expressed the view that risk assessment provided reassurance that efforts were being made to keep someone safe.

Peay (2003) found it was primarily the perception of risk to the person or the possibility of risk to others that pushed the decisions of MHAs towards some form of compulsion, other than leaving the situation to develop. Further, it was concluded that mental health practitioners consider the law based not only on what has happened but on the consequences of inaction. These findings were consistent with the findings of others (MacDonald, 2010), in that decision-making tended to be based on best interest decision-making and not necessarily based on legal concepts, such as autonomy or the process as prescribed by law. In Peay's study, practitioners made very little reference to recent case law, CoP/MHA or the MHA itself. The practitioners did not concern themselves with the detail of the legislation but more conceptually of what they thought the law allowed or should allow. The decisions made were not binary in the way that legal decisions are interpreted in court but were more complex based on the chaotic and social situations that practitioners were faced with. They were seen as operating from a value base that would not necessarily be shared by lawyers (Peay, 2003).

Another consideration in the assessment of risk is the possibility that practitioners become risk immune. Different authors, Watts & Morgan (1994) and Whittle (1997) have used the phrase 'Malignant Alienation' (p. 11 and p. 6) to describe a process in which relationships between staff and patients progressively deteriorate and staff become unsympathetic, even withdrawing support from the patient as they perceive the patient's behaviour as unreasonable, provocative or over dependant. The term malignant derives from the possibility that the misinterpretation of the patients' behaviour could lead to a person attempting or completing suicide.

Watts & Morgan (1994) argue that this phenomenon arises from the distinctive relation of healthcare staff with their patients. Unlike medical clinicians, their therapeutic tool is their relationship, therefore when the person does not recover the practitioner is prone to confuse the professional capacity to heal with their own self-worth. This is compounded by the often-slow long-term recovery of some patients, which can be interpreted as a refusal to get well. The dominance of psychiatric positivist

models of understanding also contribute to unrealistic expectations of recovery in patients. The patient side of this relationship expresses itself through inappropriate or maladapted ways of seeking help. Watts & Morgan (1994) conclude that it is essential for staff to express these thoughts and feelings openly in order to manage them safely, something it was found that was rarely encouraged within organisations. The existence of this phenomenon was identified by Logan & Taylor (2017) in the therapeutic relationships between staff and women diagnosed with personality disorder particularly in secure settings. The adoption of clinical/medical approaches to these conditions and the challenges of self-harm or self-defeating behaviours supported the view that negative therapeutic relationships often developed with particular groups of patients.

### *Summary*

The studies of Watts & Morgan (1994) and Logan & Taylor (2017) focused on inpatient settings and it is one of the gaps in knowledge I have identified regarding how working with this particular service user group of patients outside hospital affects the decision-making of AMHPs, in addition to the more traditional theories of risk assessment. How community alternatives to detention are deliberated is looked at in the next section.

## **2.12 Considering Social Context and Alternatives to Detention**

The CoP/MHA explicitly states the role of the AMHP is to take an independent view on whether detention is necessary and to bring a social perspective to this process that maximises the person's independence and considers the least restrictive alternative in line with the principles of the MHA. In the next section I look at some of the social factors relevant to detention under the MHA and the consideration of alternatives.

In a review of 97 research papers relating to mental health recovery, Tew et al. (2012) identified a range of social factors that impact upon mental health and recovery from mental illness. The key themes that they identified were practical issues such as poor housing, low income and unemployment. They also identified that these issues alongside the social stigma associated with having a mental illness were significant in the maintenance of social connectedness which impacted significantly on the service user's maintenance of mental wellbeing. Another element of this was that

of power relationships, Tew et al. (2012) identified the use of coercive powers and the paternalistic approach as disempowering the person and creating a lack of agency or “self-defeat” (p. 446), which meant service users became stuck in oppressive or limiting social circumstances. Relationships that enabled the service user to exert influence or regain personal agency were identified as an important element of recovery. Tew et al. (2012) identified the need to minimise the negative impact of hospital admission which can lead to the person becoming immersed in mental health services. This required a “paradigm shift” (p. 445) away from individualised treatment orientated practice to a form of practice that engages the service and potentially their family in collaboratively challenging the “corrosive impact of social oppression” (p. 445). This would require a shift away from the reactive approaches of safeguarding and risk management which currently dominate approaches to mental ill health and have potentially contributed to rising rates of compulsory psychiatric detentions.

The effect of social factors relating to mental illness to rates of detention was researched by Hatfield (2008). Over 14,000 assessments undertaken by AMHPs in the North West of England were analysed. One pattern that emerged was that the number of men being assessed under the MHA had increased. Hatfield (2008) notes that the age gap between men and women was significant, with women tending to be older than men. There were also a higher number of assessments for people in lower socio-economic groups, from urban areas and in social housing. Further, there were higher numbers from BME communities, particularly among African Caribbean males. Pre-existing diagnosis of a psychotic illness and co-existing substance misuse were also significant factors in the numbers of people assessed and detained. The characteristics of persons detained in Furminger and Webber’s (2009) study was similar to those Hatfield (2008) identified, with admissions being highest for those over 65 or under 30 years of age. There was a significant rise in the number of men aged under 35 and there were disproportionate numbers from BME communities, particularly people of African Caribbean descent. In Glover-Thomas’s (2011) study, some of these socio-economic factors were considered when assessing someone’s mental health, but more in terms of what support networks the person had and how social factors such as gender, race, and age had impacted on the person’s mental health. These factors were discounted as reasons in themselves for detention.

The rates of compulsory admission rose through the 1980s and 90s, although there was a short dip around the late 90s early 2000s, after which the number of compulsory admissions started to rise again. The continuation of this trend is confirmed in the CQC report (2014) which shows that the number of Section 2 applications steadily increased between 2007 (23,623 annually) and 2013

(32,524), and the number of Section 3 applications fell over the same period from 18,507 to 14,404. In terms of patterns, Furminger and Webber (2009) also found there had been a decline in admissions under Section 3 of the MHA and a decrease in informal admissions. Their research states the belief that these routes of admission have been replaced by detention under Section 2 of the MHA for a number of possible reasons.

Furminger and Webber (2009) researched the role of ASWs in the aftermath of the introduction of Crisis Resolution/Home Based Treatment teams (HBT) between the late 1990s and early 2000s. The HBTs are twenty-four hours, seven days a week services, and designed to offer an alternative to hospital admission and the option of early discharge from inpatient care. In the discussion of their findings, Furminger and Webber (2009) conclude that the experience of ASWs was that informal admissions were on the decline. Furminger and Webber (2009) also concluded that the introduction of HBT had not helped in reducing this trend and a lack of understanding of the MHA was cited as a possible reason for this. In relation to organisational culture, the transfer of practitioners from inpatient to community-based services also resulted in the transfer of working practices and organisational values and, as HBT services are mainly managed by MHTs, ASWs have been marginal to their development and operation.

The CQC (2014) stated that access to less restrictive options, such as HBT, is a factor in the rise in formal admissions and the decline of informal admissions. Furminger and Webber (2009), writing five years before the Commission's report, identified issues concerning the assessment process and the consideration of alternatives to hospital including organisational culture and resource constraints. For example, the ASWs experience was that HBT practitioners rarely joined them on assessments and the HBT culture was like that of inpatient wards, with lengthy handover meetings in the middle of the day, meaning that practitioners were unavailable at peak times when assessments were being undertaken. The lack of available beds was also cited as a reason for fewer informal admissions and ASWs expressed the belief that the bed management role attached to HBT was conflictual. The overall negative impact of these concerns was that people were more acutely unwell at the time of referral to ASWs, they were therefore more likely to be detained and admissions to hospital were inevitably longer.

Hall (2017) questions if the outcomes of MHAAs are in part driven by the availability of resources and if this is the reason for the dominance of medicalised outcomes, because sometimes this is all that is

available to the practitioners. ASWs stated that they often felt they were faced with two choices, either detention or the status quo. In other words, less restrictive alternatives to hospital are resource intensive and take time to mobilise and the ASW often has very little access to time or resources. In relation to HBT, Hall (2017) identified that there were several issues that potentially affect the outcome of the MHA in a negative way, making detention more likely. These included other professionals in HBT working to different procedures and timescales which made them unavailable at crucial times. It was identified that these organisational factors create time pressures which reduce capacity for reflective practice, making reactive decisions more likely. Hall identified that what is often overlooked by those reviewing ASW decisions is the complexity of negotiations with other organisations, who often work to different philosophies and practice cultures. Furthermore, it is often other organisations that gate-keep resources, meaning the ASW does not have direct control over resource decisions. This puts the ASW in the position of negotiator or deal maker between the patient and HBT, with the ASW often having to seek assurances from the person that they will not repeat or undertake high risk behaviour. They also need to negotiate an agreed understanding of the person's mental illness, agree timescales with the HBT practitioner, agree what resources will be available and make the HBT practitioner feel safe with their decision and recommendation. Although the primary treatment offered was medication, the ASW was also negotiating around questions of levels of emotional support, responses to crisis situations and practical support the person may require.

Hall's research identifies there is a difference in approach between ASWs and other practitioners, in this case HBT practitioners; the focus being social causation and circumstances for ASWs and diagnosis and risk for the HBT practitioners. This was identified as not entirely negative and both sets of practitioners were often aware of the different perspectives and worked toward a consensus. However, where they were unable to do so detention became more likely.

In a review of the literature of how the MHA has been interpreted and implemented by mental health professionals, Campbell (2010) identifies the consistent belief that the role of the ASW brought a less restrictive approach to MHA assessment by incorporating a more distinctive and critical social approach to mental health. However, Campbell (2010) concludes that the evidence for the specific ASW role meeting this aspiration is not convincing, and that there is little to suggest that social workers are any less medical in their approach than other mental health professionals. Campbell (2010) supports the view of Hatfield (2008) that the social profile of those being assessed and detained makes

it imperative that social workers involved in these processes have a holistic knowledge of the social factors that impact on people's mental health. Campbell found that part of the problem in attaining a more empowering and less restrictive approach is that inconsistency is often caused by organisational and resource problems. This is further compounded by the contradictory processes of trying to ensure a person's proactive engagement in their own recovery whilst working within a statutory framework where there is often little space for empowering and engaged practice. The starting point for developing engaged practice is to begin with honest accounting on the part of social workers of their limited options in the process of formal legal assessments and greater engagement with service users and carers outside these crisis periods (Campbell, 2010).

### *Summary*

The range of factors identified in the literature that impact upon the AMHPs decision to detain under the MHA, appear to be partly embedded in the practice wisdom and skill set of the AMHPs derived from their interpretation of their statutory role. The literature also suggests that these seemingly individual decision-making processes do not operate independently of the practice and cultures of other professionals and the social factors embedded in wider society. Another consideration is the relationship between MHA and other mental health legislation; in the next section I discuss the complexity that arises from the interface between the MHA and the MCA-

## **2.13 Mental Disorder and Social Work Decision-making: the Synergies and Differences between the Mental Capacity Act 2005 and the Mental Health Act 1983 (Amended 2007)**

The introduction of the MCA 2005 has created a piece of formal legislation that practitioners, including AMHPs, must adhere to when considering a person's right to make decisions (MCA applies to all those over the age of 16). The increasing influence of the MCA in the mental health field and with adults in health and care settings appears to have created additional complexities in the decision-making of AMHPs.

Rapaport, Manthorpe, & Stanley, (2009), provide a useful overview of the history of the MCA and the MHA. They point to some of the historical differences in how mental disorder has been defined and managed, describing how categories of "mental illness" and "mentally defective" (p. 92) have influenced the treatment and care of what are often seen to be distinct groups. Persons described as

‘mentally defective’ are traditionally seen as people whose minds have never fully developed, while the term ‘mentally ill’ refers to people who had previously functioned “normally” but developed a mental disorder in adulthood.

This historical split goes some way to explaining the reason for separate legislation for mental health and mental capacity. This separation was evident in the middle ages in the distinction between “natural fools” and those who “happen to fail of his wit” (Manthorpe, Rapaport, & Stanley, 2008, p.152) and can be traced in the legislation from the Mental Health Act 1959 to the present day. It may also explain some of the confusion that practitioners experience understanding the interface between the two pieces of legislation. Rapaport et al. (2009) describe the assumption made by many practitioners that MCA deals with people who have cognitive impairment and MHA people with a mental illness. What Rapaport et al. point out is that MCA and the MHA are not mutually exclusive pieces of legislation. There are times when a person could be a subject of the MHA and times when they may be a subject of the MCA or both simultaneously. People with a learning disability can experience mental health problems and require assessment or treatment under the MHA. Similarly, people who experience mental health problems, although having capacity most of the time, may experience loss of capacity temporarily or permanently. This may be due to their mental illness and the beliefs or confusion arising from it. The MHA covers assessment and treatment for mental illness, but the MCA also applies to other decisions such as medical treatment, finances, and other welfare issues.

The two pieces of legislation create other difficulties for social workers, in that they appear to be based on different approaches. The MCA is guided by the concept of autonomy if the person has decisional capacity, whilst the MHA is more influenced by paternalism and public protection. As MacDonald (2010) highlights, the MCA uses functional rather than diagnostic criteria for decision-making. Both pieces of legislation encourage less restrictive approaches to care or treatment, whether by the least restrictive principle enshrined within the MHA or use of proportionate measures in the MCA. The MHA grounds for intervention are that the person is suffering from a mental disorder of a nature and/or degree. This means that a pre-existing diagnosis of mental illness, defined in the MHA as the nature of a disorder, could be deemed enough to warrant an intervention against someone’s will, despite there being no acute symptoms at the time of assessment (Jones, 2019).

Rapaport et al. (2009) also discussed the introduction of Deprivation of Liberty Safeguards (DOLS). This was passed as an amendment to the MHA but is essentially an amendment of the MCA. DOLS were introduced to address potential breaches of the Human Rights Act under Article 5(1), deprivation of liberty, and Article 5(4), which is the right to have the lawfulness of a detention reviewed in a court. This had become necessary because of a legal judgement known as the 'Bournewood' Judgement (Allen, 2010) which concerned a young man with a learning disability who had been detained against his will and without the agreement of his carers. This was judged to be a deprivation of his liberty, as those detaining him maintained what was described as exercising "complete and effective control over his care and treatment" (Rapaport et al., 2009) (p.96). The DOLS were designed to cover people over the age of 18 years, who have a mental disorder and who lack capacity to object or consent to their treatment, either in a hospital or care home. DOLS applies to those who do not meet the criteria for detention under the MHA. If a care home or hospital believes that they are depriving the liberty of someone who lacks capacity, they should refer to the MCA and DOLS, under which, authorisation can be sought for such a deprivation. The authorisation to deprive someone of his or her liberty can then be reviewed at intervals or appealed against through the Court of Protection.

The Supreme Court ruling of March 2014, which has generally become known as the Cheshire West ruling, has implications for the MHA, although it related primarily to DoLS. The ruling indicated that anyone subject to continuous supervision and control and who is not free to leave an institution, should be protected by a legal safeguard if they lacked capacity to consent to their care arrangements. In the case of psychiatric inpatients, this would be primarily the MHA (although the MHA also applies to those who have capacity). The continued rise in compulsory detention was confirmed in an annual review of patients detained under the (HSCIC 2015); interestingly, although noting the relevance of the MCA, there was no connection made between the impact of the Cheshire West ruling and the reduction in informal admissions.

A consistent theme in the literature is the increase in compulsory detentions and the possibility that this is a result of the lack of available beds for informal/voluntary admission. The use of compulsory powers to secure an inpatient bed where a less restrictive option is a possibility and is potentially an infringement of a service user's human rights and a breach of the principles of the MHA. The trend towards increased detention is in need of further research, several recent reports (The Care Quality Commission report 2014; Department of Health 2013; Davidson and Campbell, 2010) have intimated that bed availability is a possible causative factor, but there also needs to be consideration of other

possible factors such as an increasing awareness of human rights legislation or the continued dominance of the risk agenda associated with medical diagnosis (Szmukler, 2018).

The diagnostic issue features in the findings of Hatfield (2008), who reports on the high numbers of those assessed and subsequently detained who have a pre-existing diagnosis of a psychotic disorder. The pre-existing diagnosis was also found to be a determinant factor in the perception of risk in a study by Furminger and Webber (2009), increasing the likelihood of detention. Under the MCA, the criteria for intervention without expressed consent is that, based on a functional capacity test, the person is assessed as lacking the capacity to be able to make a specific decision on a specific question. It is also important to note here that the decision is about a specific issue and not about global understanding. Someone with dementia may not have capacity on some specific issues but may retain capacity on a range of others (MCA, 2005). The MHA, in contrast, allows for the detention or treatment of an individual who may have the capacity to decline admission or treatment. The relationship between mental health and mental capacity is complex at times and presents an additional challenge for AMHP decision-making.

Rapaport et al. (2009) point out that there are similarities in the guiding principles for MHA and MCA; they both emphasise the need for autonomy and patient-centred decision-making and promote a non-discriminatory approach. One explicit difference is that the MHA makes specific reference to the protection of public safety. The criteria for detention, following on from nature and/or degree, states that the reasons for detention include that this should happen in the interests of the person's own health or safety or for the protection of others. Across the literature, it is this perception of risk or dangerousness that is regarded as the driver in the decision to detain (Hatfield, 2008).

McDaid and Delaney (2011) described the traditional view of capacity as arising from a status approach, in other words the characteristics of a person's medical or psychiatric condition. They also describe the development of a functional approach to capacity based on the person's cognitive and communicative functioning. This recognises that some people are able to make some decisions but not others. They see this as more akin to a social model of disability, as the person's medical condition does not determine the person's incapacity, although it does open the door to that person's capacity being questioned.

In a study of people experiencing a mental health crisis, who during that crisis had their decision-making capacity assessed, McDaid and Delaney (2011) identified some key themes. Firstly, people experiencing a mental health crisis that impacts on their cognitive functioning are often aware that their decision-making capacity is becoming impeded, although they may not know how to prevent this happening. Their previous experience of this happening helped them to remain aware that this was happening but they were being asked by the professionals in these situations to do something that was contrary to the coping strategies they had developed to deal with such situations. They felt that their coping mechanism to deal with these emotionally difficult situations was recognition of the need to delay significant decisions and be aware of their tendency to impulsivity. Ironically, time to process and process options were something participants did not feel they were afforded when having their mental health assessed in what were perceived to be crisis situations.

Professionals deeming them to lack capacity and therefore making substitute decisions was experienced paradoxically, in that there was resentment about decisions being made by others, although this was mixed with relief because someone was taking control of the situation when they felt they had lost control. The power play in the assessment process was identified as an important factor impacting on the person's perceived capacity. Participants described the emotional impact the process itself has on the participant's ability to make a decision; this included the participant's perception of the person assessing them. Participants identified what they saw as limitations on their ability to make a decision that were external to their control; this included being offered limited unpalatable choices such as hospital admission or no services. Also, being asked to make decisions about medications and treatments with unpleasant side effects, which may include negative impact on cognitive functioning. An alternative view of capacity was offered by McDaid and Delaney (2011), which argues that capacity is not a fixed entity but is contextual. Specifically:

“A social model of disability approach to mental health implies the recognition that capacity is constructed between society and the individual in a process of dialogue and negotiation”  
Page 740.

## *Summary*

The issue of decision-making capacity when assessing people under the MHA is a developing factor in this process, which introduces another variable in the consideration of how AMHP decisions are constructed. Writers such as Szmukler (2018) and Gooding (2017) have commented on the increasing relevance of the Convention on the Rights of Persons with Disabilities (CRPD) to which the United Kingdom government is a signatory. The CRPD identifies mental illness as a psycho-social disability and expressly forbids discrimination against anyone on the grounds of disability. Both Szmukler and Gooding view the UK's current mental health laws as being in contravention of CRPD on the grounds that the MHA is not a capacity-based piece of legislation and allows for coercive treatment of those with a mental illness. This highlights the degree to which the legal terrain on which AMHPs operate is in a constant state of change and this change is something that the AMHP needs to be cognisant of.

### **2.14 Individual Perspectives and Organisational Pressures**

The decisions an AMHP makes are framed by structural factors such as legislation and also by ideology and culture such medical concepts of illness and the associated risk agenda. This wider ideological context also needs to be considered in particular how these external considerations impact on the AMHP's interpersonal and emotional responses.

The work of Schon (1991) introduces the concept that decision-making is at its foundation a human construct which we endeavour to make professional through the application of scientific reasoning. Schon contends that for social work this is more difficult because it is based on social and not physical science. In addition to this the impact of other subjective factors such as relationships and individual emotions need to be considered. Peay (2003) concluded that the application of mental health law is an interpretive and fluid exercise of constructing facts, and that the law cannot force practitioners to see the world in the same way and can only set boundaries on their decision-making. The law is therefore interpreted differently dependant on the professionals involved and the situation they are presented with including multi-disciplinary decision-making which has professional and power relations which have an influence on outcomes.

Dwyer (2012) observed that much of the pressure and influence in AMHP decision-making was the practicalities and real time pressures of mobilising an assessment and the feeling that the AMHP is responsible for an entire process including finding doctors, arranging ambulances, negotiating inpatient beds, and so on, whilst at the same time containing the distress felt by the service user and the family. Dwyer describes the aspiration by the AMHP to exercise good authority in situations of high pressure and concern, which has an inevitable effect on the AMHPs own wellbeing, with a potential negative effect on the decision-making process. Dwyer highlights the feeling expressed by AMHPs that the sharing of the decision-making with an AMHP colleague was something that helped to ease the pressure, but this often had to wait until after the event. The reality is that the AMHP is often left in situ with the service user when all the other professionals have left, they must deal with the individual distress of the person and their family drawing on their own internal resources.

A similar theme was identified by Gregor (2010) who found that AMHPs themselves often felt isolated and that their role was misunderstood by others, including their own line manager; peer support was identified as an important way of addressing these feelings but was not always available. The multiple pressures of making decisions which placed pressure on the individual AMHP were identified as working with limited information and limited time, and these were said to be compounded by dealing with complex decisions whilst holding the responsibility for liaising with others, including police, doctors, ambulances and inpatient wards. Despite all this the AMHPs believed their role was a valuable one and believed it brought an alternative perspective to the process despite these pressures.

The research by Morriss (2015) identifies a theme of AMHP work being a less prestigious form of social work, or “dirty work”, (p. 703) as it involved the forcible detention of service users. Morriss concludes that there are elements of this conflict for AMHPs, as they know that the wards in which people are detained to, often do not meet their aspirations of a therapeutic environment and the lack of resources make the process emotionally draining for them. At the same time, the AMHPs believe that their independent perspective is a safeguard for the service user at a time of crisis in their life. Vicary, Young, & Hicks, (2019) pick up the theme of dirty work as described by Morriss, researching the experience of AMHPs during MHAAAs, they described the behaviour of doctors “shifting” (p.15) responsibility to the AMHP elements of the assessment process they consider to be dirty work. This was described in relation to the extent to which the doctors remained involved in the process once the formal part of the assessment had been concluded. AMHPs described doctors often leaving the

assessment once the medical recommendation had been completed leaving them to negotiate and coordinate the person's admission. It was acknowledged that there was no explicit expectation in the legislation that the doctor should remain involved but the AMHPs did express that they did not see the doctor's behaviour as satisfactory. Where there was a clearer shifting of dirty work included the doctors expecting the AMHP to identify an in-patient bed for admission, despite this being an explicit responsibility of the doctor in the MHA. There was evidence that this behaviour was driven by hierarchical deference, although there was no evidence that Nurse AMHPs showed any greater degree of deference than social work AMHPs, Vicary et al. (2009) note how the negative experience for AMHPs including additional pressures, potentially leads to poor experiences for those beings assessed.

Coffey et al. (2016) considered the factors that service users identified that would make them more likely to engage positively with mental health practitioners. These included having a stable and trusting working relationships with them. However, service users often felt that the co-production of risk management plans was often inhibited because the practitioners gave the impression of being more concerned about deflecting responsibility and avoiding risk to themselves or their organisations. The work of Watts & Morgan (1994) looked at the sometimes-intense interpersonal nature of mental health work and how the interaction with others experiencing distress can negatively impact on a practitioner's ability to remain objective.

### *Summary*

The use of self in therapeutic relationships with people who behave in ways that practitioners may find personally challenging may impact on the practitioner's view of self. The worker can perceive the person's repeated use of maladaptive behaviours as failure on their own part and can potentially lead to feelings of anger and frustration on the part of the professional, leading to negative cycles of interaction. Watts & Morgan (1994) concluded that an essential method for avoiding these negative cycles was for staff to be able to express these thoughts and feelings openly so they can be managed safely. This was seen as a way of reducing the negative impact on the worker and their subsequent ability to remain objective.

## **2.15 Chapter Summary and Research Aims**

There was a consistent theme across the literature that would suggest that decision-making in social work, AMHP and other mental health work contains elements of what has been described as framing of problems (O'Sullivan, 2011; Russo & Shoemaker, 1992; Schon, 1991; Strachan & Tallant, 1995).

There appears to be a process in which the AMHPs and other professionals use knowledge acquired through training, practice experience and professional culture that is applied to different situations. There also appears to be a cautious theme that there are possible negative consequences to this process unless there are balances in place to contextualise assumptions, which requires a process of active de-biasing (Strachan & Tallant, 1995). There was no research that looked specifically at the use of frameworks of understanding by AMHPs to inform their considerations and decision making. Therefore, there was no research that identified what frameworks of understanding were used and how they were constructed or related to each other. There was no research into how AMHPs construct and deconstruct these frameworks of understanding, or how they interact with the frameworks of understanding constructed by other participants in the MHAA process.

The literature reviewed shows that decision-making in relation to the principles of the MHA is complex and multifaceted and involves a range of objective and subjective elements which interact with the beliefs, values and experiences of individuals to inform and influence the decisions that are made in respect of mental health service users. Situated within a context characterised by debates on social (constructivist) versus medical (positivist) approaches, a political/economic climate marked by austerity and cuts in social care that impact mental health services and legal rulings that can significantly change the landscape from day to day, understanding the impact of these factors on AMHP decision-making is important. The literature identified the statutory role of the AMHP in considering factors other than medical diagnosis and other factors impacting on mental health and illness. This included the consideration of service users' social circumstances. However, there was not any literature that looked at how AMHPs position themselves in the debates around mental illness and how the views they hold inform their interpretation of the legislation and interaction with other professionals, families and service users.

Equally important to examining these external environmental factors is the need to consider subjective factors, such as the influence of the values and beliefs of AMHPs. Stone (2018) concludes that AMHP decision-making is subjective as AMHPs "observe, interpret and construct risk factors individually" (p. 12). Consideration of this subjectivity needs to be factored into the analysis of what the AMHP tells us shapes their decision-making. AMHPs are required to be reflective regarding their own risk thresholds and the disproportionate effect this may have on their decision-making. The current research looked at various elements of the subjective part of this process but did not attempt

to connect this with the overall or total process of AMHP consideration and decision making during a MHAA.

Issues identified in the literature reviewed also included access to resources to prevent detention or restricted access to inpatient beds, differing interpretation of the key principles of the MHA (Davidson and Campbell, 2010; Furminger and Webber, 2009; Hatfield, 2008), pragmatism on the part of the AMHP arising from the subjective nature of decision-making or because of the identifiable thought processes of different types of decision-makers (Osmo & Landau, 2001; MacDonald, 2010; Rapaport et al., 2009). As the DOH (2013) and the CQC (2014) make clear however, there is an urgent need for research which increases understanding of the role of subjectivity and pragmatism, as well as other factors in the variance of outcomes for service users. Other research has considered some or all of these elements but either refers to the decision making of ASWs rather than AMHPs, looks at the decision making of mental health professionals as a generic group or considers component elements of AMHP decision making. This research looks specifically at the decision making of AMHPs, when considering requests for detention within a legal framework, their concepts of mental illness, associated risks and how this relates to other contextual factors.

The purpose of this study is to understand the decision-making processes of AMHPs and the factors that influence community assessments as a whole, with data gathered from AMHPs themselves. The review of the literature revealed gaps in knowledge in understanding the interpretative process that AMHPs engage in and the meanings that they attribute to the behaviours of service users which in turn, influence the AMHP assessment. The purpose of this study is to further develop our understanding of the decision-making processes of Approved Mental Health Professionals and the factors that influence Mental Health Act assessments in community settings; its aims were:

1. To explore the frameworks of understanding AMHPs use when considering using the compulsory powers of the Mental Health Act 1983 (Amended 2007) for individuals in a community setting.
2. To identify factors, they take into consideration when considering or undertaking assessments in community settings that inform the construction and deconstruction of these frameworks of understanding
3. To examine the subjective interaction between the AMHPs interpretation of the legal process and other factors such as the personal beliefs of the AMHP, other participants views, finite

resources, and consideration of consequences. A process boundaried by law but influenced by a dominant medical mental illness and risk agenda.

### 3. METHODOLOGY

#### 3.1 Design

The purpose of the study is to explore the factors that influence AMHP decision-making. The investigation of this subjective human activity required a qualitative investigation to understand the complex relationship of the processes within the context in which they occur (Edwards and Talbot, 1999; Gillham, 2009). In developing the research design, several methods were considered. For example, an ethnographic approach may have been appropriate to observe the work of AMHPs or enquire immediately after the MHAA about the process of decision-making. This could have enabled a more immediate capture of data. As Bryman (2004) suggests, an ethnographic approach need not just be an anthropological study of others or a sociological study of culture. The researcher can observe covertly or overtly and, even though they will in some way influence the behaviour of participants, awareness of this can be factored into the researcher's analysis. I concluded however, that direct observation of the process of an MHAA would be intrusive for service users and could add to the distress they were experiencing, which I felt would be unethical. It was important to the aims of this study to build in a process of reflection of real practice that could have been possible with an ethnographic study incorporating retrospective interpretation. To understand our actions, we need to isolate and identify behaviours and be able to recognise the feelings and beliefs that influence them. It is this active engagement with the material, as Bolker (1998) suggests, that enables the researcher to do more than just passively accumulate data and for the research participant to construct meaning out of their experiences. However, even with retrospective consideration of real practice, the extensive differences of each assessment would need to be factored into the analysis.

As a practitioner working in the role of an AMHP, I also considered using an action research approach incorporating the process of self-reflective practitioner, which would involve the use of self-reflective analysis of my own practice and that of other practitioners working on similar tasks, within my own sphere of work. This process of applying theory to practice and evaluating the outcomes to create cycles of change also has the appeal of having a direct impact on improving practice (Denscombe, 1998). I discounted this as a primary approach because I was concerned that being both researcher and the subject of the research would create serious difficulty in objectively analysing the research

findings. Furthermore, as with an ethnographic approach that attempts to unobtrusively observe participants in the process of an assessment, self-reflective practitioner research would create practical and ethical difficulties due to the highly sensitive circumstances under which these types of assessments take place.

Another approach considered was a grounded theory approach, which allows the researcher to look at the actions of individuals as they interact with the multitude of factors that impact on the assessment process. In grounded theory studies, new theories are developed as the evidence emerges from a process that requires the researcher to be immersed in the theatre of social activity (Edwards and Talbot, 1999). Two factors convinced me this would be difficult to achieve: my experience as an AMHP and being involved in the kinds of decisions being studied means that I had begun the process of developing a theory prior to undertaking my research, whereas grounded theory requires the *absence* of a-priori theory. Secondly, the literature review has led to the identification of a theory of understanding the process of AMHP decision-making. The theoretical propositions identified from the literature review are central constructs within the phenomenon being explored and, therefore, a method which enabled the testing and development of theory was considered most appropriate. The type of investigation and the research questions lent themselves to a Case Study design which involved the testing and development of a predetermined theoretical position. The Case study approach is discussed in more detail later in this chapter.

The evidence was gathered in two stages, firstly in-depth interviews with AMHPs using a fictitious case vignette which focused on the process of a MHA assessment and the factors considered as part of this. The second stage of evidence gathering was done by holding a focus group of AMHPs which sought to explore underlying themes relating to the MHA and the role of the AMHP. These are discussed in more detail below.

### **3.2 Ontology, Epistemology and Methodology**

The positivist versus relativist discussion runs at the heart of the debate about mental illness and claims about what we believe to be 'true', as can be seen from the literature reviewed above. This discussion also runs through all endeavours to make sense of the social world when researching human behaviour and, in the context of this research, human decision-making.

Any definition of mental illness, or belief in the existence of something called mental illness, must consider theories of existence (ontology) and philosophical approaches to the theory of knowledge (epistemology), which support claims of what it is possible or desirable to know (King & Horrocks, 2010). The nature of this debate is often described as the realist versus relativist approach to deciding what it is possible to know about the material world and human existence (Moses & Knutsen, 2012).

This philosophical discussion assists in analysing the different schools of thought relating to mental illness and disorder and how different writers approach this question. It is also fundamental to the question of research. The researcher has to take a position as to whether there is a material reality that exists independently of human mental construction. The methods of investigation that we use flow from the beliefs we hold about being able to study the social world. Some researchers take the view, or theory of knowledge (epistemology) that there is no material reality that exists independently of human consciousness, all understanding must therefore be premised on the assumption that all that is achievable is a description of how the researcher perceives the perceptions of others (Moses & Knutsen, 2012). Elements of this constructionist view are evident in the philosophical schools of post structuralism, social constructionism and hermeneutics. These relativist views of human society focus on the construction of meaning through language or discourse. Although it would be too crude to state that constructionist writers such as Foucault did not believe in any material existence, social constructionists consider that human behaviour or existence only becomes a material reality when it is interpreted by others. Therefore, this can only be understood through the analysis of language and discourse. As Burr (2015) concludes, this leads to the possibility of many realities with no way of asserting which is the correct one or which view has more validity than another.

This has strong echoes of idealism arising during the enlightenment, a school of philosophy that emphasised the development of a rational society through the progress of enlightened thinking. The outside world was therefore considered to be a reflection of the conscious mind and the construction of a progressive society would be the result of the development of progressive ideas (Moses & Knutsen, 2012). These relativist or interpretivist approaches to ontology and epistemology would therefore focus primarily on the subjective experience of the individual and would be limited in being able to make any generalised claims about truth and reality.

On the other end of the spectrum are realism and structural approaches to both ontology and epistemology. This view is supported methodologically by the positivist school of social science and like idealism began development during the enlightenment. The realist approach views existence as a material reality that exists independent of the human mind, regardless of whether human minds understand or acknowledge its existence. A realist (ontological) approach accepts there is a material reality and, although accepting that not all knowledge is available to us, believes (epistemologically) that with the correct methods of investigation the nature of existence can be explored and uncovered (Moses & Knutsen, 2012).

In a similar fashion, a structural approach believes there to be a material explanation for human behaviour and the nature of human societies. History can be understood through the concepts of epochs, beliefs can be understood through the organised dominance of ideology and power relations can be understood through the economic interests of elites within given modes of production. The writing of Althusser (1918-1990) reflects the belief that it is the economic organisation of society or economic base that directly determines the political and ideological superstructure of that society. According to Althusser, in relation to human agency, individuals, groups or classes are essentially trapped by an all-powerful political, legal system backed by dominant ideology. This ideology is a determinant factor in the development of institutions such as religion, education and the legal system. A purely deterministic approach to ideology and power would be unable to consider a more dialectical approach, which considers the contradictory nature of existence in a society even when it is dominated by powerful elites. Even in totalitarian societies, human experience and conscious examination of experience in relation to ideology, creates critical analysis (Burr, 2015).

### **3.3 Critical Realism**

These philosophical schools, which at first appear diametrically opposed, are at the same time inter-related. It needs to be acknowledged that within each school of thought there are subgroups and schools that polemicise in different directions or blend different schools of thinking. In the school of realist thought, Burr (2015) differentiates what she describes as naïve realism from critical realism. Naïve realism is the contention that the social world is a fixed entity that we can observe, analyse and classify. The social world exists in concrete forms and can be studied using the same theories of being

and knowledge that exist, for example, in geology and accordingly, it would be possible to uncover the nature of the class structure of society using the same ontology and epistemology. Burr contends that such extreme approaches to realism rarely exist and more commonly an approach of critical realism is applied.

In critical realist terms ontologically, there is a material world that does exist independently of human thought and interpretation. Human beings, and the social world they inhabit, are part of a material reality. For critical realists, knowledge and understanding and material existence are not separate and the relationship between the two is not determined by material structure or individual interpretation alone. For critical realists, there is a dialectical relationship between the material world and our understanding of that world. Rather than there being a fixed reality in the material world there is constant change. Human beings are not just subjects of a material reality, they are agents. Language and consciousness are not merely reflective or interpretive of a material existence they play an active part of shaping the material world and social reality. The naïve realist allows their senses to tell them about the world they inhabit. The critical realist does not accept this sensory approach uncritically, although believes what their senses tell them is informed by a material reality (Burr 2015). Pilgrim (2014) differentiates between transitive and intransitive reality when dealing with the question of ontology and epistemology within critical realism. Intransitive reality (ontology) exists independently of human experience or understanding whereas transitive reality is bound up by the context of human activity, all enquiry and all enquirers (researchers included) as well as theory and values implicit in their approach.

The enquirer therefore is part of the object of enquiry, as all work, including empirical research, is mediated by cultural context, norms and social settings. Although critical realists start from the belief that there is an intransitive reality, they acknowledge that human society has less structural stability than the physical world and is in a more constant state of flux. Baskar (1997) uses the analogy of a map and warns against mistaking a map for the actual physical terrain as it is merely a representation.

The view the researcher takes of ontology and epistemology also requires consideration in relation to methodology. If the researcher's view is that social being is brought about by social interaction rather than behaviour being determined by genetic predisposition, their method of enquiry will reflect the view that they hold (King & Horrocks, 2010). The realist thinker may err towards the use of quantitative

methodology as this could be considered to have greater efficacy in the discovery of facts rather than opinions. The relativist thinker may consider qualitative approaches as more appropriate as they allow for greater scrutiny of our beliefs and subjective experiences. A critical realist perspective considers human consciousness and human agency as part of a material reality. Therefore, the theory of being and the theory of knowledge both contain elements of realism and relativism. We are not entirely the creators of our own destiny, and at the same time, we are not prisoners of our biology or social circumstances. Our circumstances may limit and influence our choices, but a degree of volition still exists.

The critical realist researcher therefore sees a connection between cause and meaning. Pilgrim (2014) argues that critical realism is incompatible with both psychiatric positivism and post structuralism. Critical realism accepts the intransitive nature of positivism and the transitive nature of post structuralism but differs from both as it starts from the ontological and epistemological view that the two are inseparably connected. The methodological debate transcends the debates in positivism and post structuralism and acknowledges that sometimes quantitative and sometimes qualitative methods of inquiry are appropriate, or a mixture of the two (Pilgrim, 2014). "A CR form of enquiry into mental health topics should respect methodological pluralism and theoretical exploration" (Pilgrim 2014 p. 999). Therefore, qualitative approaches that enquire how or why actors such as AMHPs make decisions within legal frameworks and other contexts remain open to the critical realist researcher. For the researcher who takes a naïve realist approach to ontology and epistemology, the behaviour and actions would be considered to be determined by their biology or the given structures of their society and an empirical or quantitative approach would be required to discover facts and causal factors. The critical realist researcher believes that language and subjective views are grounded in real experiences and other independent factors, and an investigation of all these elements can be undertaken using qualitative methodology (King & Horrocks, 2010).

The use of critical realism which is sometimes called critical research (Humphries, 2008) allows the researcher to start from the perspective that there is a material reality that exists, and the constructed social world is part of that material reality. This allows the researcher to make claims about understanding the social world, both in terms of its material reality and the current ideas that are generated from that reality. Critical realism recognises the significance of human agency and conscious action, therefore an enquiry into the decision-making of a group of professionals in this case

AMHPs supports the adoption of a qualitative methodology. Critical realism also recognises that human agency and consciousness are contextual and operate within structures that are time and place specific (Pilgrim, 2017). In this study they are professional decision-makers, operating within the legal framework of mental health legislation, policies, resource constraints and professional expectations. Although it is not possible or maybe even desirable to control all the variables in an investigation. The dichotomy that the critical researcher is summed up in this way by Humphries (2008)

“Critical social research cannot be easily located within either a realist or a constructivist paradigm .... It is anti-positivist in the sense that it acknowledges the problem of interpreting meanings in social life. At the same time, it does not deny the existence of objective facts, and indeed insists on examining the institutional structures that constrain and control relatively powerless people” (pg. no 106)

I have taken a critical realist perspective in relation to the underpinning theory of this research, its methodology and the interpretation of the evidence. Critical realism/critical research is not prescriptive in relation to the methods of investigation (Humphries, 2008) and allows the researcher to consider a range of methods of evidence collection, which will be discussed next.

### **3.4 The Case Study Approach**

A significant feature of the case study approach is that it can be used to investigate theoretical propositions that are pre-determined using theory-building and theory-testing in the design of the research (Humphries, 2008). It has also been suggested to be an effective method of investigating identified phenomena in context (Denscombe, 2003; Humphries, 2008). Yin (1994) noted the distinctive role of theory development in the case study approach prior to data collection which differentiates it from other methodological approaches, such as ethnography and grounded theory, in which previously developed theoretical positions are not required. Yin (1994) further states that the theoretical propositions arising from the research questions and exploratory work including the literature review, guide the data collection and analysis of the material. The case study method involves exploring problems in naturally occurring settings without consciously trying to impose sterile controls or influence outcomes. Yin (1994) regards the case study method as a preference when a

contemporary phenomenon needs to be studied in its natural setting or context. This perception of participants as experts and not merely as a source of data is also supported by Humphries (2008) as it enables the researcher to consider incomplete or contradictory findings in the context of the participant's world.

The advantage of a case study is that the researcher can focus on the context of the phenomenon by interviewing the participants who are or were part of the process under investigation which can be particularly useful in social work (Gilgun, 1994). As the decision-making of AMHPs is believed to be influenced by multiple variables and be multi-layered, it required an approach which could factor in all these facets. Gilgun titles this approach as a "Thickly described case study" (Gilgun, 1994 p.371), which, in this study included multiple individual perspectives comprising a 'unit' in order to explore a particular phenomenon (AMHP decision-making). The approach used can be described as Idiographic, a single unit of study with multiple perspectives requiring a thematic rather than statistical form of analysis and which enables the building of a picture to test or develop theory. The process is one of testing hypotheses by investigating the evidence that supports or refutes the initial contention.

There are several models of case studies and there are advantages and weaknesses with each. The type used in this study is theory confirming or theory fitting case study, (Moses and Knutson, 2012), or hypothesis testing as described by Gilgun (1994). The case is defined by Miles and Huberman (1994) as, "a phenomenon of some sort occurring in a bounded context. The case is, "in effect, your unit of analysis" (Miles & Huberman, 1994 p. 25). The use of a theory-confirming case study enabled research into the complexity and shifting contexts in which AMHP decision-making (the phenomenon being explored) takes place. The research design included an examination of the assessment process from the perspective of the AMHP and used a method which simulates decision-making in the present, while simultaneously facilitating reflection of the impact of internal (subjective) and external (environmental) factors (drawing from professional experience) on the process. This approach provided the most appropriate method for comparing how beliefs and actions confirm, disprove or develop theory about AMHP decision-making, with reference to a range of influencing factors (the bounded context) (Miles & Huberman, 1994: Moses & Knutson, 2012).

The theoretical propositions for this case study, as derived from the literature review, can be summarised as follows: *the process of AMHP decision-making involves a range of objective and*

*subjective elements which interact with the beliefs, values and experiences of individuals to inform and influence the decisions that are made in respect of mental health service users.*

The testing of this theory was achieved by exploring the phenomenon of AMHP decision-making within the contexts in which these decisions take place, investigating the factors that influence the assessment process and how and why AMHPs progress towards an outcome. The research was carried out by focusing on parts of the process and the comparative outcomes. The context being the AMHP as an individual, part of a social group and as part of an organisation. The AMHP decision-making process was therefore conceptualised as a single synchronic case that includes several individual cases (practitioners) with common features (the AMHP role) (Prosser, 1995).

To make claims about reality required the setting of boundaries, such as the decision-making of AMHPs in a single locality, working under the same legislation subject to similar local policies and resource constraints. It was also decided to limit the decision process to assessments undertaken in the community, rather than broaden it out to all legal decisions made by this group. To ensure further consistency across participants, a fictitious vignette was developed to enable a comparison of how different actors responded to the same questions. Individual interviews were conducted, and the participants were invited to respond as they believed they would in practice.

The use of this structure, combined with the participants' freedom to play with the material and add their own meaning, gave the opportunity for the researcher to present a realist scenario and interact with the participant to gain insight into how the AMHP creates their model of what is happening in the fictitious vignette and explain the process of their decision-making. The transcripts of these interviews were interrogated to explore both individual perceptions and decisions and also to identify any consistent themes within and across the interviews. The context and underpinning beliefs of this bounded group was further investigated by the inclusion of evidence from a focus group of AMHPs, the rationale for this is further developed below.

### **3.4.1 Context of the Case study**

In this section I will describe the context that AMHPs were practicing in. This includes the demographics of the local authority, including where available, information about patterns of mental ill health. The AMHPs in this study were all employed by a single local authority in the north of England.

(References for statistics have not been provided as they identify the local authority concerned, they are available on request). The population of the district is approximately 332,000, making it the 18<sup>th</sup> largest authority in England and Wales. Indices of Multiple Deprivation ranked the local authority as the 67<sup>th</sup> most deprived out of 326 districts in England and Wales. 12.5% (40,459 people) of the population live in neighbourhoods that are classed as being in the top 10% most deprived. The percentage of the population identified as other than White British in 2001 was 3.3%. In 2011 this figure was 11%, the largest minority group identified was 'other white', the largest group being from Poland.

The ONS statistics from 2016 indicate that 20% of the population of the local authority recorded high anxiety scores and records from GPs identified 26,900 (9.6%) of adults in the district had an unresolved record of depression, against the national average which is 8.3%. There were an estimated 32,700 people with common mental disorders causing emotional distress in the same year which correlated strongly with the areas of high deprivation, 10% of the population in these areas were described as experiencing these types of problems. Between 2013 and 2015, 55 men and 23 women were recorded as having ended their life by suicide and in 2014/15 there were 714 hospital admissions due to intentional self-harm.

The prevalence of more severe mental disorders was generally lower than the national average across the district as a whole but was higher than the national average in the city centre and areas of high deprivation. In the age group 18-64, there were estimated to be approximately 810 people who were diagnosed as having a psychotic disorder such as schizophrenia, affective psychosis or bi-polar disorder. There are an estimated 910 people (aged 18-64) diagnosed with borderline personality disorder and 710 diagnosed with antisocial personality disorder. There are an estimated 14,600 (aged 18-64) people diagnosed with two or more psychiatric disorders, this is known as comorbidity or dual diagnosis. These disorders include common disorders such as depression or anxiety along with post-traumatic stress disorder, attention deficit disorder, eating disorders, alcohol and drug dependency, suicidal behaviour and self-harm.

At the time of the interviews, the provision of community mental health services primarily was from integrated health and social care community teams across the district. These included two recovery-in-psychosis teams, two wellbeing teams, two assertive outreach teams, an early intervention-in-psychosis team, forensic psychiatry, ADHD team and two older people's mental health teams. There was also a community based 24-hour crisis and home-based treatment service.

The majority of AMHPs (approximately 25) were located within these integrated services. The other AMHPs (approximately 10) were employed and managed directly by the local authority and were located in learning disability services, children's services, social care first contact and four AMHPs were also employed to undertake assessments as part of the out of hours' service. In this local authority, there were no health professionals other than social workers who were approved to be AMHPs. The AMHP workforce was composed entirely of social workers and, with one or two exceptions, those workers were employed by the local authority. The majority of AMHPs though, were based within teams managed under joint arrangements with the Mental Health Trust. When the focus group was undertaken there had been a reorganisation of community mental health services which meant the way in which the services were organised was slightly different and some of the team descriptions had changed.

The allocation of assessment requests for daytime MHAs was that, where possible, the request for an MHA for someone known to services was managed/undertaken by the person's allocated team. There was also a daytime rota with two AMHPs who were on call to assess people not known to a team, or where no team AMHP was available. Requests were either managed by the team the person was known to or they were considered by an AMHP coordinator who received and considered requests via a social care call centre. These requests were primarily from health and social care professionals, GPs, local hospitals, acute and psychiatric hospitals, family members or the police. Local records indicate that, in the year 2016, 515 requests were considered by AMHPs in the local authority area; 121 were requests for assessments for people currently in the community. This does not include those in residential care homes, A&E departments, places of safety or other requests for people not currently psychiatric in-patients.

In total there were 25 individual AMHPs involved in the study, 18 in the interviews and 7 in the focus group. The demographics for the AMHPs are provided in the two separate findings sections.

### **3.5 Methods**

#### **3.5.1 Design and Rationale**

The data collection took place in two stages. The first stage was the undertaking of 18 individual semi structured interviews. The interviews were completed over about six months and were transcribed as soon after the interview as time allowed. By transcribing as the interviews were undertaken I was able to consider emerging themes and make a judgement about when enough interviews had taken place (saturation) to start the process of more detailed thematic analysis. This continuous analysis of the data also enabled me to identify some of the gaps that were emerging in the data particularly in relation to the more ideological or subjective elements of decision making. To be able to explore these in more detail I decided to undertake a focus group with AMHPs to explore these subjective elements.

#### **3.5.2 In-depth Interviews**

In-depth interviews with 18 AMHPs were undertaken. A fictitious vignette was developed to give context to the discussion. The information contained was given to the AMHP as they requested it. This was supported with questions for the AMHP to ensure that the evidence gathered allows comparisons across the case study (Humphries, 2008). The case vignette and questions were amended following a pilot interview. This was done to ensure there was a wider scope to the interview and a greater breadth of information achieved.

This enables exploration of the same issue from the different perspectives of different actors from different work settings to generate deeper understandings of the phenomenon under investigation (AMHP decision-making). In-depth interviews with a relatively small number of practitioners are, as Denscombe (2003) argues, particularly appropriate when using a case study approach with only one unit of investigation. Although small qualitative studies do not allow for generalisation across a large number of participants, this is not the purpose of such research. Interviewing a small number of participants gives the researcher greater opportunity to explore actions, feelings and meaning in much greater detail (Yin, 1994; Gillham, 2009; Edwards and Talbot, 1999). This binding of the study, as described by Yin (1994) and Baxter & Jack (2008), prevents the research from becoming too broad and

creating unachievable objectives for a study of this nature. 18 AMHPs were interviewed; this was not an arbitrary number but was guided by a number of principles as outlined by Mason (2010). Firstly, as a piece of qualitative research I was not aiming for large numbers of participants as the aim is not to record frequency of responses but quality of content. As Mason further points out, increasing numbers of participants leads to diminishing returns and saturation of data is not the aim of qualitative research. The number of participants was decided using Mason's guidance from a review of PhD studies, which identified 15 as the minimum number of participants for this type of study and 20 to 30 being the norm. I also reviewed the numbers of participants involved in similar PhD studies in the literature, which included Morriss (2015) 17 participants, Gregor (2010) 24 participants and Stone (2018) 20 participants. In addition to the 18 interviews, a further 7 AMHPs not involved in the interviews took part in a focus group. The AMHPs were recruited from different work bases: Community Mental Health Services including Recovery in Psychosis, Wellbeing, Early Intervention, Assertive Outreach, Learning Disabilities, Forensics, Home Based Treatment, Children's Services, and Out of Hours. The AMHPs were recruited from a single local authority and the data analysis was undertaken alongside data gathering. The advantage of interviewing AMHPs within one authority is that it allows comparison of individual decision-making within a single system and can help to control for external factors, such as resource constraints and demographic variations. Conducting the study within one authority has also allowed for comparisons such as the AMHP's view of inter professional differences and organisational differences within a single system. The participants were selected by the use of non-probability sampling which Yin (1994) associates with case study research which tends to focus on the use of small samples. The intention is not to make inferences from statistical data about wide populations but to study real life phenomena. The participants were not randomly selected as they were part of a bounded study within a single local authority and they were all AMHPs. Permission to approach the AMHPs to be involved in the research was gained from their employing authorities following university ethical approval for the research. The participants were invited to participate via an email that was sent to all AMHPs in a single local authority. The AMHPs who expressed an interest were then sent a letter of invitation that explained in more detail the purpose and format of the research. Individual interviews were then arranged at their place of work or another convenient location. A private interview room was used and prior to the interview the process of the interview was explained before the participant was asked to sign a consent form. The explanation included the rationale for recording the interview and how the recording would be stored which included downloading the digital recording and password protecting access to its contents. Following the interview, a period for debriefing was built in; this was not recorded.

### 3.5.3 Vignettes

The decision to develop a fictitious vignette flowed from the adoption of a qualitative case study method and the use of semi-structured interviews to gather the data. The use of vignettes is recognised as a valid method of collecting data (Maguire et al., 2015) and was used in at least two of the studies reviewed in the literature (Peay, 2003; Stone, 2017). There is a discussion in the literature about the advantages and disadvantages of using a fictitious vignette versus drawing on actual cases. It is suggested that the use of fictitious vignettes may encourage the respondent to answer questions based on what the interviewee believes the interviewer wants to hear, rather than talking about what they would do in practice (Hughes, 1998; Barter & Reynold 1999). In addition, there was also the possibility that because vignettes do not involve real-time pressures such as lack of resources or the influences of other decisions, the information gathered may not be reflective of real practice. However, it is also acknowledged that the way in which people recall actual events can be erroneous (Peay, 2003) and descriptions may be based on how the interviewee wishes to be perceived, rather than describing what they actually did. Furthermore, it has been posited that the opposite contention may also be true, that the use of fictitious vignettes has certain advantages over asking interviewees to comment about real events as it separates the person from actual practice and therefore enables less defensive responses (Maguire et al., 2015). O'Dell, Crafter, de Abreu, Cline, (2012) suggest that the use of a fictitious vignette can put respondents at ease and enable them to talk about a situation hypothetically. Although this could be described as simply creating a narrative between interviewer and interviewee, there is research value in that the analysis can seek to identify the process of constructing a story interactively between the two participants (MacIntyre et al., 2011). The focus would then become the person's feelings and subjective perceptions and would include the identification of what normative views and socially approved views are evident in the process of decision-making (O'Dell' 2012). The aim may not necessarily enable the researcher to predict specific behaviour, but as Jenkins, Bloor, Fischer, Berney, & Neale, J. (2010) highlight, qualitative vignettes are more an attempt to gain insight into "the social components of the participants' interpretative framework and perceptual processes" (Jenkins et al., 2010, p. 1780).

An issue that is raised in the literature is the validity of the research based on the degree to which the interviewees have confidence in the authenticity of the vignette (Jenkins et al., 2010). If the

respondents feel that the vignette accurately reflects real life experiences, the more likely they are to engage with the material and to reflect on their own real experiences and use these to explain their views, (Sowislo, Gonet-Wirz, Borgwardt, Lang, & Huber, 2017). To address this question of validity of the vignette, the material was initially created by drawing on my own personal experience of MHAs. I distilled this down to a single continuous vignette and then broke it down into stages, starting with information the AMHP is likely to receive at first referral and then holding back information until it was requested or until it felt appropriate to offer additional information. The vignette was created as a dynamic tool, with new information being added at key stages echoing, as far as possible, the way in which events would unfold in practice. This design created the opportunity to discuss real life decision-making based on a scenario developed from real practice (MacIntyre et al., 2011). The design of the vignette was undertaken by drawing on my personal experience of community MHAs, my experience as an AMHP professional lead and teaching of AMHP trainees. As part of this role I have regular discussions with other AMHPs about the assessments they have undertaken, this collective experience was synthesised into a single vignette which was designed to reflect the unfolding patterns and challenges of a live scenario.

This process was refined by including an AMHP in the discussion on the design and then piloting (Sowislo et al., 2017). Piloting is an essential stage in the development of a vignette in order to ensure it has authenticity (Maguire et al., 2015). This led to some minor changes in the narrative but, more importantly, led to a change in style of interview from asking specific questions on the information the participants would receive to creating a more fluid approach, which allowed the AMHP to lead the discussion. Following the information being given, if nothing was forthcoming from the AMHP they would be asked “What would you do next?” or “What are your thoughts now?” The use of open-ended questions allows the participant to explore contextual factors that may be unique to the systems and processes they work within (Maguire et al., 2017).

“Vignettes are particularly suitable for exploring levels of consistency between decision makers: by asking decision makers to respond to a common scenario they allow a comparison of decision makers responses to the same stimulus” (Maguire et al., 2017 page 244)

The vignette was designed as a continuous narrative (Jenkins et al., 2010) to increasingly challenge the AMHP and raise concerns with new information. This was to reflect the process of real-life information gathering. The last stage did, in all cases, lead to the decision to detain, but that was achieved by asking the AMHP in the final stages about the factors they would use to eliminate the least restrictive options.

### **3.5.3.1 Vignette and Introduction**

#### **Case Scenario**

At the beginning of the interview the following short statement was read to the AMHP:

“I am going to ask you to think about how you receive a request for a Mental Health Act assessment. I will ask you about what information you would expect to receive and how you would proceed. I have a fictitious Scenario to work through and I will give you the information as you request it. I will also ask questions for clarification as issues arise. This is not a test of your knowledge and is intended to prompt discussion about how you as an AMHP would respond to the issues you are presented with. You can ask for the information to be repeated at any time, please feel free to take notes and refer to the Mental Health Act Manual, Code of Practice or Reference Guide provided. There are also some supplementary questions I may ask as we progress.”

After this statement had been read, part A of the vignette was read out. The AMHP was then asked for their thoughts and comments on this information and what they might do next. The interview was a fluid process and the AMHP was encouraged to ask for further information or clarification on what had already been presented. The AMHPs were asked some additional questions or what they said was reflected back to clarify meaning. There were two specific questions asked at the end to all participants.

## **Part A**

Call received from SCD – you are on the AMHP duty rota.

Mr X is a 37-year male. Lives alone in his own tenancy. Is known to community mental health services. He has missed his recent appointments with his care co-ordinator and outpatient appointments. Neighbours and family are expressing concerns that his mental health is deteriorating. Concerns include Mr X shouting at his neighbours and family stating that “everybody is out to get him” and “if people don’t leave me alone, I am going to end up in hospital”.

An MHAA has been requested by his community mental health team.

## **Part B**

### **Information from Community Team**

Mr X has been known to CMHT for approximately 10 years. He has a diagnosis of bi-polar affective disorder although his care coordinator informs you that on a previous admission nursing staff expressed the belief that his symptoms of hyper-mania were caused by misuse of illicit substances and his presentation was more suggestive of an emotionally unstable personality disorder.

Mr X has had three previous admissions to hospital: one informal voluntary admission, lasting about a week. Mr X discharged himself on this occasion. On the second occasion, he was detained under Section 2 of the Mental Health Act, on this occasion he became an informal patient after three weeks and was discharged from hospital after four weeks. It was during this admission he was diagnosed with Bi-Polar disorder and he was started on mood stabilising medication. His latest admission was three months ago, he was initially admitted subject to Section 2 MHA later converted to Section 3. The explanation for this detention under Section 3 is that he refused to accept his diagnosis and need for medication or support from community mental health services. Mr X was discharged from his detention under section by a Mental Health Review Tribunal. At his tribunal Mr X stated that he accepted his diagnosis, he was willing to take his medication and accepted support from the community team. Mr X also stated that he had used cannabis to help him relax but now acknowledged that his drug use may have contributed to him becoming unwell.

## **Previous Symptoms of Mental Illness**

When unwell Mr X is described as being volatile in mood. He is confrontational with his family and neighbours. He accuses them of interfering in his life and has on occasions made allegations that people have been in his flat and read his mail, moved things around and taken things without his permission.

Mr X has been separated from his wife for approximately 12 months although she did not leave the family home until his recent admission. Their two sons aged 10 and 15 live with their mother although they continue to visit Mr X and stay overnight at the weekends. Mrs X has previously stated that she loves Mr X, but she has left because, when he becomes unwell, he repeatedly accuses her of having affairs. She has stated that his periods of illness are disruptive and distressing for their sons.

He has a history of cautions from police for anti-social behaviour towards his neighbours and members of the public.

Mr X has a history of expressing suicidal thoughts in the past when low in mood. He has taken two previous intentional overdoses; the last occasion was 11 months ago.

## **Part C**

### **Current Concerns**

#### **Community Mental Health Team**

Mr X was visited following his discharge from hospital, as part of a 7 day follow up. On this occasion, there were no concerns about Mr X's mental health. Mr X stated that although reluctant he would take his medication and accept support from services. Since this visit Mr X has not attended appointments and has not answered telephone calls.

CMHT has received telephone calls from his family expressing concern about Mr X. They have also received information from his housing association regarding complaints from neighbours some of which have resulted in calls to the police.

## **Part D**

### **Mr X's ex-Partner**

Mrs X does not want to discuss her ex-husband. Her sons are continuing to visit their father, they have not expressed any concerns to her just to say, "Dad is Dad, what do you expect?", when asked how he is. She informs you that if she is worried about the boys, she would stop them visiting their father.

### **Mr X's mother**

Mr X's father died 10 years ago. Mr X's mother described the relationship with his father as strained and there were lots of arguments between them. She informs us that her deceased husband was a heavy drinker and could on occasions be verbally aggressive and physically violent.

Mother describes her son as loving and caring towards her and his children. She believes that many of his problems arise from his marriage and that his wife was too critical and controlling of her son.

She does not know what is wrong with her son but described him as "a bit of a dreamer" "he didn't get on well at school", "likes to keep himself to himself". She informs you she does not think he is looking after himself and worried that he is not eating properly and looks tired all the time. She does not want to be responsible for "locking him up" but thinks "the professionals should decide what is best for him".

### **Mrs X sister**

Mrs A believes that her brother is very unwell and needs to be in hospital. She describes him as very hostile towards her and paranoid about the family. She is close to Mr X's ex-partner and states that it is unlikely that she has had any relationship with other men. She is worried about the strain his behaviour is creating for their mother and informs you that her Mum has always covered up for her brother. Mrs A is adamant that her brother should be in hospital before he hurts himself or somebody else.

## **Part E**

### **Additional Information**

Mr X does not have any criminal convictions for violent offences. There is an alert on his case records that he physically assaulted a healthcare professional during a previous admission.

Mr X has said there is no way he will ever go back to hospital. He has said to his mother that he will “run away and no one will ever find him, if they try to lock him up again”.

There are currently no inpatient beds available locally.

### **Part F**

#### **Assessment**

Mr X is at home when you arrive. He speaks to you from the bedroom window. He states that he is fine, and it is everybody else who needs locking up.

Mr X eventually allows you into his home.

Mr X is agitated at the start of your interview. Informs you that he feels he is being constantly monitored by others and that your presence is making him feel worse.

Mr X believes that his involvement in mental health services has been a mistake and that his behaviour is different to other people but being different to other people is not a problem.

Mr X states that the neighbours do not like him because he is different. He accuses them of racism and states that liking Reggae music and smoking cannabis is his only crime.

Mr X believes that the housing association want him out because he is a single man in a 3-bedroomed house.

Mr X believes the police are working with the housing association because none of them want his “type” in the neighbourhood

Mr X does not accept that his family have genuine concern about his wellbeing. He believes they are working with his ex-wife to get him into hospital. He believes his ex-wife plans to move back into the house when he is in hospital and change the locks.

Mr X believes his ex-wife is having a relationship with the housing association estate manager and they have “cooked up this plan together”.

Mr X states that his ex-wife and the estate manager are members of a secret organisation “The illuminati”. He states the belief that he thinks his sister may also be involved and it is a well-known fact that mental health services are under the control of the “illuminati”.

**Additional Questions:**

1. What do you hope a hospital admission will achieve for Mr X?
2. Do you experience conflict with other professionals during the process of undertaking Mental Health Act Assessments?

### **3.5.4 Focus Group**

The semi-structured interviews undertaken with AMHPs gave insights into how the decision to undertake assessments was made and the factors that were taken into consideration; this was also reflected in how the conclusion was reached within the assessment itself. The evidence pointed to the presence of risk in various potential and actual forms as a key driver in the decision-making process. Because the AMHPs were asked about process this is primarily what they talked about. What I also wanted to explore was the underlying beliefs that were less explicit in the discussion of process. The underlying themes I wanted to further explore was their beliefs about the nature of mental illness itself and how this is perceived within the context of their role as an AMHP.

Social Work England, the body which regulates the training of AMHPs expect candidates to meet the following knowledge criteria to be eligible for approval.

- Understand a range of models of mental disorder and be able to apply them in practice.
- Understand the contribution and impact of social, physical and development factors on mental health, and be able to apply this in practice.
- Understand the social perspective on mental disorders and mental health needs in working with service users, their relatives, carers and other professionals, and be able to apply this in practice.
- Understand the implications of mental disorders for service users, their relatives, carers and other professionals, and be able to apply this in practice.
- Understand the implications of a range of treatments and interventions for service users, their relatives and carers, and be able to apply this in practice.

The semi-structured interviews did draw out some evidence of how these factors affect the decision-making process of AMHPs, but not strongly or clearly enough to be able to make clear evidential claims. The responses gave strong evidence about the criteria considered when considering undertaking an assessment and making decisions about a course of action. This addressed the criteria under the MHA of risks to the person's safety or with a view to the protection of others. There was some consideration of the criteria of health concerns, but it was apparent that further investigation was necessary to confirm AMHP's beliefs about the nature of mental illness, its causes, possible treatments and the role of mental health legislation. The establishment of a mental disorder of a nature and or degree is identified in the MHA as a necessity before a medical recommendation or application for detention can be made. Therefore, I believe it was important to clarify how mental illness is understood by AMHPs and how these impacts on the assessment process. The purpose of the focus group was also to add depth to the interviews and further explore why the AMHPs believed mental health legislation, in relation to mental illness, was necessary. The focus group allows the researcher to observe how a particular group of professionals express their collective understanding of their role and also how this understanding is collectively developed (Brannen & Pattman, 2005).

The use of focus groups is identified in the literature as a distinct method of research that gathers evidence through group interaction, discussing topics presented by a researcher. This is distinct from methods such as nominal group technique which also include group interviews, but which discourages interaction between participants (King, 2010). Focus groups can exist along a continuum from formal to informal approaches, but they tend to be distinct from methods such as brainstorming or citizen

juries as the facilitator, rather than the participants, is principally in charge of setting the parameters and directing the questions (King, 2010).

There are advantages and disadvantages of using focus groups as a way of gathering information. For instance, there is the possibility of developing group think, where individuals amend their contribution to fit in with the dominant view or, there is the risk of strongly opinionated individuals dominating the discussion (Linhorst, 2002). The counter to this disadvantage is that group norms are easier to identify in group situations and that group discussion is a more naturalistic approach to analysing decision-making than individual interviews, as this better reflects how decisions are made in real situations. Although some individuals may feel less comfortable speaking in groups, some participants may feel more comfortable with a group rather than in a one to one situation (King, 2010). This process of making links between the person's individual and the group's collective experience is more realistic in many ways and reflective of daily practice of professionals like AMHPs, more so than some other methods of investigation (Brannen & Pattman, 2005).

There are various reasons for using focus groups in research including: initial exploration and pre-testing interview questions (Linhorst, 2002). In this instance, however, I chose to use a focus group as a way of triangulating themes that had already emerged from undertaking semi-structured interviews. As highlighted above, the semi-structured interviews identified strong themes about risk as a determinant within the decision-making of AMHPs. This could suggest that detention under the MHA is primarily about risk containment rather than therapeutic recovery. The decision to follow up the analysis of the semi-structured interviews with a focus group was to further explore AMHP beliefs about mental illness, and how this might contribute to decisions in the context of a MHAA. The focus group has similar advantages to semi-structured interviews for gathering qualitative data in that individual responses can be explored by the facilitator or by the intervention of other participants (Humphries, 2008).

The use of a focus group with AMHPs also had the potential advantage of being able to consider how, as a group, the participants formulated and maintained group identity. Morriss (2015) observed that AMHPs used the forum of a group discussion to tell Atrocity Stories which they co-narrated. Morriss believed that this was an identifiable method of how AMHPs develop and maintain their cohesion as a group and how they defined themselves as different to others. The use of a focus group in this study gave the added value of observing this process in action.

The use of a focus group in this context is consistent with the qualitative methodological approach I have adopted based on the ontological contention that there is a consistent underlying reality, even though epistemologically this reality is interpreted and understood subjectively. This critical realist approach was used to inform the adoption of a bounded case study approach. As with the semi-structured interviews, the participants were selected from a single professional group of AMHPs working for a single local authority. This ensured that boundaries of the focus group were the same as for the semi-structured interviews, which means that while evidential claims can only be based on the study of a singular group, the contextual variables such as local policies and procedures remain consistent across groups (Humphries, 2008).

The focus group consisted of seven AMHPs selected from different parts of the service and who had not previously been involved in the study. This was to ensure that, if findings from the research were presented, they would not feel defensive about my interpretation of the previous data. The qualitative nature of the focus group limits the number of participants possible and the extent to which findings can be generalised; this was factored into the analysis. The number of participants was intentionally kept below 10 as the literature (Brannen & Pattman, 2005; King, 2010) advised this optimises discussion and therefore the quality of the evidence.

The participants for the focus group were also selected by the use of non-probability sampling (Yin, 1994) Permission to approach the AMHPs to be involved in the research was gained from their employing authorities following university ethical approval for the research. The participants were invited to participate via an email that was sent to all AMHPs in a single local authority. The AMHPs who expressed an interest were then sent a letter of invitation that explained in more detail the purpose and format of the research. The AMHPs were selected from respondents who had not previously been involved in the interviews. A private room was used for the focus group and prior to the focus group the process of the focus group was explained before the participants were asked to sign a consent form. The explanation included the rationale for recording the discussion and how the recording would be stored which included downloading the digital recording and password protecting access to its contents. Following the focus group, a period for debriefing was built in; this was not recorded.

The focus group was facilitated by me, the researcher. An observer was also in attendance, their role was to observe the group and take notes but not intervene in the discussion. The purpose of this was to observe the interaction of the group and pick up on non-verbal cues and dynamics that might be missed by myself or the recording. The observer was a social worker but not an AMHP, they sat outside the discussion group to emphasise their role as separate. Prior to the discussion, the purpose of the research was explained as well as the rationale for using a focus group. The group was encouraged to contribute to the rule setting and discussion about confidentiality was used to put the participants at their ease (Linhorst, 2002). I explained my role as facilitator and that I would be presenting questions but would only intervene in the discussion to seek clarification, guide the discussion back to the topic if necessary and encourage the participation of the entire group. The use of appropriate humour was encouraged, as this has been identified as a positive way of encouraging group participation. I also included an observer who was introduced to the group and their role was also explained, which was to remain silent and observe, take notes and be involved in a debriefing session afterwards. Participants signed consent forms and were informed of their right to withdraw consent at any time. I presented a pre-selected question to the group and further questions were presented arising from the discussion. A limited number of questions are advisable in focus groups to give scope for the group to be able to direct some of the agenda and therefore explore factors the researcher may not have considered (Linhorst, 2002). The question presented was: **Do we need a Mental Health Act?** The discussion was then mainly directed by the participants, I only intervened to seek clarity or to initiate discussion if the discussion appeared to be drying up. The focus group was audio recorded and the discussion was transcribed verbatim and thematic analysis was used to interrogate and interpret the data.

### **3.6 Participants**

#### **3.6.1 Interview Participants' Profiles**

The participants were recruited from a single local authority, all the AMHPs received a letter of invitation and were then free to volunteer for the research. The AMHPs in this particular local authority were based in a range of services and towards the end of the data gathering process a purposive selection of participants took place to ensure that the interviews covered as wide a range of services as possible.

There were eighteen AMHPs involved in the interviews; they were all social workers and approved by a single local authority. There were ten women and eight men and four of the participants were of BME heritage. Five of the AMHPs had practiced in the previous role of ASW. One had been in practice over 15 years, seven, ten to 15 years, seven, five to ten years and three under five years. All the AMHPs were currently in practice with a single local authority but three had previously practiced in other local authorities. Seven of the AMHPs worked in mental health teams for working aged adults, two in an older people's mental health team, one out of hours, two in a learning disability team, one in a forensic team, one in an early intervention team, one in a children's team, one a generic first contact team and two in the professional support team. The findings are now presented below.

Participant	Workplace/Team	Gender	Profession	Years Approved as ASW or AMHP	Qualification
A1	Early Intervention	M	Social worker	9	AMHP
B1	Professional Support	M	Social worker	26	ASW/AMHP
C1	Learning Disability	M	Social worker	12	ASW/AMHP
D1	Well Being	M	Social worker	9	AMHP
E1	Assertive Outreach	M	Social worker	8	AMHP
F1	Older Peoples	F	Social worker	9	AMHP
G1	Older Peoples	F	Social worker	8	AMHP
H1	Recovery in Psychosis	F	Social worker	7	AMHP
I1	Recovery in Psychosis	F	Social worker	3	AMHP

J1	Learning Disability	M	Social worker	4	AMHP
K1	Social Care Direct	M	Social worker	4	AMHP
L1	Forensic	F	Social worker	11	ASW/AMHP
M1	Children's	F	Social worker	10	AMHP
N1	Recovery in Psychosis	F	Social worker	11	AMHP
O1	Professional Support	M	Social worker	11	ASW/AMHP
P1	Well Being	F	Social worker	9	AMHP
Q1	Out of Hours	F	Social worker	13	ASW/AMHP
R1	ADHD	F	Social worker	11	AMHP

### 3.6.2 Focus Group Participants' Profiles

There were seven AMHPs involved in the focus group; they were all approved by a single local authority, although one practiced independently. There were five women and two men and three of the participants were of BME heritage. Four of the AMHPs had practiced in the previous role of ASW. Two had been in practice over 15 years, one ten to 15 years, two five to ten years and two under five years. All the AMHPs were currently in practice with a single local authority but three had previously practiced in other local authorities. Four of the AMHPs worked in mental health teams for working aged adults, one in an older people's team, one out of hours and one independently commissioned to undertake work on behalf of the local authority.

Participant	Workplace/Team	Gender	Profession	Qualifying Year	Years Approved	Qualification
S1	Enhanced	F	Social worker	2017	1	AMHP
T1	Independent	M	Social worker	2012	6	ASW/AMHP
U1	Core	F	Social worker	2016	2	AMHP
V1	Older Peoples	M	Social worker	2005	13	ASW/AMHP
W1	Out of Hours	F	Social worker	1999	19	ASW/AMHP
X1	Enhanced	F	Social worker	2009	9	AMHP
Y1	Core	F	Social worker	2002	16	ASW/AMHP

### 3.7 Insider Research and Reflexivity

As an AMHP myself, I have had to be cognisant of the effect that being an insider researcher had on the research process in particular how this can skew the gathering of evidence and its interpretation. Humphries (2003) identifies how social work itself has increasingly promoted a rational technical approach leading to cognitive behavioural approaches, managerialism, legalism and outcome driven audits to support this. The focus has therefore become evidence-based practice, requiring research based on these principles' objectivity or naïve realism. White (1997) describes the attempt to achieve an entirely objective view as positivism, based on the assumption that the world is full of objective facts waiting to be discovered and if it cannot be measured it does not exist. White insists that empirical quantitative data should not automatically be considered to be superior to qualitative approaches, as all knowledge claims are contingent on the adding of contextual factors and the views of participants in the research process.

Insider research and insider knowledge are identified as important in researching sensitive and difficult topics (Babbie & Rubin, 2001), even though the researcher is potentially less objective in their approach and frames of reference for understanding. They have the advantage of being immersed in the culture of their subjects and are able to analyse this world from a unique perspective of practice knowledge (Babbie & Rubin, 2001). Humphries (2003) goes further and contends that social work is a moral, social and political activity that requires the researcher to use methods of inquiry that explicitly consider uncertainty and confusion.

White (1997) proposes that often there is a false duality in social research between social science and practice wisdom and that in many ways social worker methods of enquiry have the same traits of much qualitative research. Both fields of enquiry are described as being based on assumptions which may turn out to be correct but are equally susceptible to inaccuracy. White describes how social work, claims or "(c) aims" (p. 741), to be external and detached in the way situations are interpreted, when in reality, the unavoidable immersion of the social worker in people's lives brings the objective and the subjective together. White describes social workers as natural ethnographers by the very nature of what they do but cautions against any exclusive claims by social workers of being able describe the totality of a given situation. Fook & Askeland (2006) assert the importance of applying critical theory

to our perceptions, and although not rejecting objectivity as a goal, acknowledges the need to situate our beliefs historically, politically and philosophically.

As an AMHP and mental health professional lead for the local authority, which was the main site for the research, this could have potentially created conflict for those considering taking part in the study. There were some factors that were built into the research design and implementation that aimed to achieve a more objective outcome such as; the letter of invitation made it clear that participation was voluntary and that the right to withdraw without detriment was always an option during the research process. The vignette used in the interview was fictitious and it was clearly explained that the research is an exploration of the process of decision-making and not a test of an individual's knowledge of the law. As suggested by Babbie & Rubin (2001), there is an inevitable subjectivity to any research but more so when the person is an active participant in the area. This issue was also addressed by reflexive scrutiny in supervision. Fook & Askeland (2006) describe reflexivity as our ability to understand that our involvement in a situation as a researcher or practitioner will have an influence on what happens and therefore requires consideration. It is also an acceptance that all these factors will have an impact and create limitations on what we can claim including the possibility of reactivity, meaning that what we experience may also be a reflection of our actions. We, therefore, need to view ourselves as a lens through which we interpret the world, and this lens has social, cultural and individual emotional elements.

This reflexive approach enabled me, as a researcher, to reflect on the impact of this on my objectivity and, at the same time, develop insights into the findings that would be missed by a non-participant researcher. The use of a fictitious vignette gave the AMHP a structure and familiar dilemmas to work with, whilst avoiding the use of confidential information. This method did not allow for exploration of real time pressures involved in assessments and this was also factored into the analysis. Despite these safeguards being built in, it was still important to have cognisance of the hidden exercise or experience of power. In relation to practice and research, Fook and Askeland (2006) propose that for the positive use of power to be fair and effective, it requires the recognition of power relations being present. Otherwise where power is being exercised negatively it will create resistance, although this is not in itself seen as negative as long as there is recognition of the fact.

Another advantage for the insider researcher is that the process can enable them to reflect upon their own actual practice and, at the same time, reflect upon the practice of others. This includes the

development of the practitioner researcher's unique insights and theory of practice. This requires them to apply theory to practice and develop new insights into institutional practices and belief systems (Argyris & Schon, 1974). This is something Hughes (1999) contends is more achievable using the case study method, as the variables that are being considered are not separated from events, structures and processes that give meaning to them. In addition, the case study methodology allows or encourages the researcher to adopt a range of methods or tools of inquiry including the use of multiple methods.

White (1997) contends that practitioner researchers cannot and should not make claims to be entirely neutral, they are practitioners who make decisions in real situations which they are then often required to defend. Humphries (2003) develops this point by describing and critiquing the "evidenced based approach" (p. 81) that has become the dominant model of practice within social work and which makes claims to identify universal laws of human action. This positivist-based approach is identified as paradoxically failing to challenge biased views by failing to acknowledge that the collection and presentation of all facts are influenced by partisan interpretation. Research is never a neutral activity, what is researched and how it is researched is always a political activity, Humphries (2003). White believes that although social workers are natural researchers, they do not have an exclusive right to claim the truth, they need to accept that objective truth will always be out of reach. The necessity of making decisions therefore needs to be tempered by being open about the theoretical position we have used to reach those conclusions.

Hughes (1999) argues that the use of a case study approach enables the researcher to adopt a theoretical position which accepts there may be multiple realities that participants experience and describe. The exploration of these multiple realities within the single context of a case study grounded in practice can allow the practitioner researcher to acknowledge this as a reality. They can also factor in that they are not a naïve researcher and that they start from a theoretical viewpoint. This is not considered to be problematic, as long as the researchers acknowledge that they have knowledge of their subject whilst at the same time they are testing that knowledge. It is the willingness to reflect on current beliefs using the tools of new knowledge and experiences that can give rise to new insights.

The use of a reflexive approach is also recognised by Ripamonti, Galuppo, Gorli, Scaratti, & Cunliffe, (2016) as a legitimate method in discovering underlying values, conflicts and interests that are not immediately apparent within organisations but can provide a collaborative way for practitioners and

academics to explore how communities or individuals conduct themselves. Ripamonti et al. (2016) place the reflexive approach of action research within the ontological framework of social constructionism. They contend that the social world does not exist independent of our perceptions. Self-reflexive research by the practitioner researcher therefore needs to be premised on the participant's willingness to accept that their taken for granted assumptions will need to be challenged. The researcher's organisational role, and the degree to which they are embedded within organisational structures and cultures, also need to be consciously reflected upon. This view is also supported by White (1997) who proposes that the researcher should identify their location in the research and the need for additional consideration including a reflexive approach.

The views of Hughes (1999), Ripamonti et al. (2016) suggest that reflexivity sits within a social constructionist ontological view, in that they view reality as an interpretation by social actors. I would contend that their description of how social actors interpret their world is also close to Pilgrims (2014) description of transitive reality and sits comfortably with the critical realist perspective I have adopted. The impact of being an insider researcher and the implications of this has been considered reflexively in the conclusion.

### **3.8 Ethical Considerations**

There were a number of ethical considerations in the design and undertaking of this research.

#### **Service user confidentiality**

The first consideration was the possible harm to service users that AMHPs come into contact with, if their confidentiality was not maintained. With regard to the interviews a fictitious vignette was designed which gave the AMHPs a realistic framework of an assessment but did not ask them about specific assessments they had been engaged on. In the process of the interviews AMHPs did on occasions make reference to actual assessments they had been involved in as a way of answering a question or illustrating a point. Any identifying information was removed during transcription and editing. A similar process was undertaken in the focus group at the beginning of the focus group the participants were informed that they were being recorded and were discouraged from using detail that could be used to identify service users. During transcription and editing all identifying details such as names of towns, local authorities or countries of origin were removed.

### Participant confidentiality

The AMHPs anonymity was also a consideration, reference to the AMHPs employing authority has been removed also names were removed and replaced with codes. The AMHPs inclusion in the research was voluntary and the purpose of the research was explained in writing beforehand and verbally at the beginning of the interviews and the focus group. It was also explained to the AMHPs in writing that they had the right to withdraw permission to use the information that they gave me at any time. Although an AMHP myself I had no managerial authority over any of the participants and therefore there were no identified conflicts of interest or power relations to factor into ethical considerations.

### Impact on the participants

Although all the AMHPs had experience of real MHAA and associated stresses, I still thought it was important to consider the impact that talking about MHA work in a structured and detailed way might have on the participants. It was explained to them that the interviews were not a test of their knowledge but were an exploration of their thoughts and beliefs during the consideration of a MHAA. Time was provided at the end of the interviews and the focus group to allow the participants to debrief and unpack issues that the process had raised for them.

There was additional consideration given to the impact on the participants in the focus group. As a professional group they are experienced participants in professional meetings and training events. This requires them to consider and challenge the opinions of others in a respectful way. To reinforce these established practices the focus group participants were invited to create group rules which included listening to the opinion of others, challenging respectfully and maintaining confidentiality outside the group. The focus group did address some challenging issues and an informal debriefing period was available at the end of the formal discussion with the co facilitator and me.

The research received ethical approval from the University of Huddersfield.

## 3.9 Data Analysis

The interviews were recorded and transcribed. Analysis took place in three stages using thematic analysis of the transcripts. (King & Horrocks, 2010). The process is broken down here into stages,

although as King & Horrocks note this rarely progresses sequentially and there is a degree to which the researcher moves backwards and forwards between stages.

The analysis contains elements of both deductive and inductive reasoning. The use of case study approach and the adoption of a critical realist perspective allowed for the development of an a priori theory. In summary, the theoretical position generated from the review of the literature was that as a group of professionals undertaking the same legally established roles, AMHPs would adopt identifiable frameworks of understanding that were influenced by their statutory duties but also other variables. This deductive proposition allowed for the design of research that would aim to capture these elements through the use of a bounded case study with a single unit of study (AMHPs within one local authority), a single continuous vignette for the interviews and a single set question for the focus group. The rules that govern AMHP work and the fact that they have to make decisions as part of that role allowed me to ask them why they as individual AMHPs make particular decisions or as a group they were asked to explain their beliefs about the legislation they work with.

This created the structure and the boundaries of the discussion and allowed for the identification of frameworks of understanding that AMHPs used and patterns relating to these patterns. There had been no predetermined theory about what particular patterns would emerge but with the reading of the transcripts, patterns relating to the consideration of risk and underlying patterns relating to the MHA criteria for detention and principles were observed which required an inductive approach to the material to allow the flexibility to consider what these patterns might tell us. The stages of analysis are now discussed below.

### **3.9.1 Stage One**

This involved three separate readings of five selected interviews, and which eventually led to the development of a system to identify thematic strands. The initial analysis was started by the reading through of the scripts at the time of transcription and then by selecting five scripts that were read through in detail to identify themes around the decision-making of AMHPs. This first purposeful reading of the transcripts without codes or intention to find codes allows the researcher to familiarise themselves with the overall context of what is being said by the interviewees. During the second reading of the selected transcripts I started to identify statements by the interviewees that related to the research question; in particular requests for specific information, reflection on information they were given, statements about the particular importance of this information or the consideration of options. These areas were highlighted using highlighter pens and a colour coding system was developed to identify when the AMHP was considering options or making decisional statement. The

colour coding was used to identify emerging themes such as historical factors and current issues of concern. These factors were then coded in relation to the MHA assessment (see Appendix 8.3).

These codes were then applied to the analysis of all the transcripts. In the early stages there was an element of experimentation to see if themes could be clearly defined or if there were multiple factors within statements. The theme that emerged consistently in decision making was that of risk. Risk was present when considering the person's history, it was also present when considering current concerns leading to the request by others for an assessment, the planning of the assessment and in the final considerations of which course of action should be taken. It was apparent from this analysis that risk was a significant factor at key stages of the assessment and that there were also inter-professional differences of perceptions of risk.

The main themes were:

1. Theoretical forms of risk, including actuarial risk, forensic/historic risk and current/clinical risk which were consistent with significant themes identified in the literature.
2. How risk impacts on the decision to undertake an assessment, how the assessment is undertaken and how risk impacts on the options decision. This included the consideration of the necessity, urgency of an assessment and in the final considerations of which course of action should be taken.
3. How different participants/interested parties may consider risk differently.

The sub themes were developed as it became apparent that there were different elements with the themes. The complexities and multi-layered nature of risk required further taxonomies to be developed which incorporated codes but also enabled a more systematic and coherent method of managing the data across the 18 transcripts. I first created an overarching thematic grid (below) and this gave rise to three other grids: risk grid for MHA assessments; conflict grid and expectations grid (these are discussed in subsequent sections) which show the relationship between main themes and sub-themes. The thematic grid was populated with quotations relating to the identified themes.

### 3.9.2 Thematic Grid

Main Themes	Sub Themes	Quotation	Comments
Theoretical forms of risk	Actuarial		
	Forensic/Historical		
	Current/Clinical		
How risk impacts on the decision to undertake an assessment, how the assessment is undertaken and how the risk impacts on the options decision	Necessity of an MHAA		
	Urgency of an assessment		
	How to undertake assessment		
	Deciding outcome of an assessment		
How different players may consider risk differently	Difference of opinion:		
	Other practitioners		
	Doctors		
	Family		
	Service User		
	Police		

	Ambulance		
	Others		

### 3.9.3 Stage Two

After the findings from the individual interviews in stage one had been subjected to a comparative thematic analysis involving data from all participants (a lateral process) to explore commonalities and differences in decision-making across different actors, the identified themes relating to risk were confirmed to be present across all participants. Because the theme of risk was confirmed to be present and dominant in the identified considerations and interactions of the AMHP it was decided to subject this area of decision making to further scrutiny.

Using the theme of risk all the transcripts were then searched again electronically using the key words risk and other words commonly associated with risk including danger, neglect, harm, deterioration, self-harm, suicide etc. The sections containing these words were extracted and read in detail.

This process identified that there were similar questions or factors that the AMHPs sought information about the individual's history or the current situation. This process confirmed the presence of risk as the key factor in the consideration and decision-making of all the AMHPs. This process resulted in the building up a conceptual picture of the risk elements involved in AMHP decision-making across roles and settings. A second series of thematic grids was then developed relating to these identified risk themes and the elements contained within them. This included an overarching risk category such as historical risks, further broken down into areas explored by the AMHP such as mental health history, risks arising from mental health in the past etc. These areas were then populated with the questions the AMHP asks relating to these areas explored.

The second grid looked at current risk concerns and a third grid looked at risks established following assessment and future perceived risks, these grids were also broken down into areas explored and populated with questions asked or statements made by the AMHP. Two further grids were also developed looking at the conflicts AMHPs experienced with other professionals and their expectations for the person following detention. These grids identified the specific areas AMHPs used to interrogate

the situation they were presented with and the factors they considered pertinent to making a decision. The research was designed to identify factors that AMHPs consider when involved in MHAs and the interaction between different identified factors. During the process of analysis patterns were identified and classified in relation to risk which also started to indicate the possible underlying structure to these factors. Whilst completing the second stage of analysis it became apparent that although the legislative framework and its CoP was not always explicitly stated, there was emerging evidence that the factors considered appeared to relate to the criteria for detention under the MHA and the associated principles. I decided to do further scrutiny of the data to see if this was a consistent pattern.

### **3.9.4 Risk Grid/Risks Explored in a MHA Assessment**

Examples of the blank risk grids are presented below; the populated versions are in Appendix 8.6.1. An overarching risk category such as the person's past history was identified, which was then broken down into sub categories such as mental health history, history of harm to self and others, these subcategories were then broken down in the specific questions or statements the AMHP was making at that time. The same process was carried out in relation to current perceived risks as an overarching theme, which was then broken down into the sub themes of what is being requested and why, context of current risks, current mental state, risks to self, risks to others. These sub themes were then populated with the questions or statements from the AMHP, later (Stage Three) these statements/questions were matched against MHA criteria for detention and the MHA principles. This method was repeated in the thematic grids for Risks explored in a MHAA, Conflicts experienced in a MHA, Expectations expressed in a MHAA.

Risks Explored in a Mental Health Assessment		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)

Risks Explored in a Mental Health Assessment		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)

### 3.9.5 Conflicts Grid/Conflicts experienced in a MHA Assessment

The two specific questions relating to the conflict AMHPs experienced with others during assessment and the desired outcome of detention in hospital were similarly analysed thematically and presented in their own grids. These themes were then used to cross reference with earlier findings about risk and decision-making in the transcripts. The data and themes were exhaustively examined (Yin, 1994) and have been discussed in relation to the initial research aims, questions and theoretical positions drawn from other relevant studies (Edwards & Talbot, 1999).

The grid below collates the responses from the AMHPs about what the conflicts of opinion they experience with others during the assessment process. These were also coded at a later stage three in relation to the MHA criteria for detention and its principles. Completed version appendix 8.6.2.

Conflicts Experienced in a Mental Health Assessment		
Overarching Category	Areas explored (plus codes)	Specific questions (plus codes)

### 3.9.6 Expectations Grid/ Expectations expressed about a MHA Assessment Outcome

The grid below collates all the responses from the AMHPs about what they expected an admission to achieve for Mr X. Again, they were additionally coded against the principles of the MHA and the criteria for detention/principles. Completed version Appendix 8.6.3.

Expectations about a Mental Health Assessment outcome		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)

### 3.9.7 Stage Three

The third stage of analysis took place after all the transcripts had been searched using the key word “risk”, associated words and words associated with decision making. The paragraphs which included these terms had been scrutinised for their content/meaning and used to populate the various evidence grids. It was during this process that it became apparent there was a strong correlation between these statements and the criteria for detention under the MHA and its principles. After the statements were considered thematically and collated in grids (see appendix 8.6.1.to 8.6.3) the factors were then mapped against the legal requirements of the MHA and its code of practice using the analytic codes (below). The strong correlation identified during this process of analysis between the legal criteria for detention under the MHA including its principles and the structure/content of the AMHPs decision making guided the structure of the findings chapter. The analysis of the data identified that the AMHPs use frameworks of decision making that are dominated by risk which take place within the dominant framework of statutory legislation. The questions and statements were matched against the analytic codes developed that related to the MHA criteria for detention and MHA principles (see Appendix 8.3).

### 3.10 Focus Group Analysis

The focus group discussion was recorded and fully transcribed. The transcript was kept as close to the original discussion as possible, including interruptions, agreements, and laughter. This enabled the

analysis of the transcripts to take cognisance of the group process and evidence of 'group think' or the telling of Atrocity Stories or Co-Narration. Some of the grammar was corrected, as the dialect and vernacular could have made it difficult for the reader to understand. Given the objective of the focus group, it was important to ensure that the analytic method aligned with the inductive, exploratory approach pertinent to the research as opposed to a confirmatory method, such as that driven by specific questions. Therefore, thematic analysis was used. This involved a three-stage process: first, I undertook an overview reading of the transcript in order to apply initial descriptors to sections of the text. The second stage of analysis required listening to the recording multiple times and taking side notes to identify further descriptors and ensuring 'exhaustion' of the data. During this process, I also looked for unexpected findings. These descriptions were then interpreted to suggest possible meanings and a further reading of the transcript identified key themes. In extracting themes from the transcript, I took account of how extensive and specific the comments were and assigned weight to meanings depending upon emphasis and the extent to which participants agreed/disagreed on the issues raised. There was no concern that individuals were coerced into ways of thinking and the group overall was a free exchange of ideas, beliefs and experiences through which one participant would raise a point that others found pertinent and this was then developed by the group. There were five key themes identified: the MHA as a legal safeguard; critical views of mental illness; the social causation of mental illness; admissions to hospital due resource issues and, the AMHPs' perceptions of detentions being driven by the service user.

The themes are presented in the findings chapter in discursive format to allow the discussion to be contextualised and considered in relation to their significance for understanding how AMHPs make decisions. Quotes used to illustrate the points made are those I viewed as exemplar in conveying meaning, however, all the data relevant to a specific theme was used. The themes are compared with the literature to confirm previous findings or identify alternative perspectives.

In merging findings from the two research methods used in the study, a final process led to the focus group themes being re-scrutinised to identify if there were patterns that had emerged during the interviews. This confirmed that the dominant theme in the study is the management of risk to the person and others although focus group findings had generated evidence of a more critical approach to how AMHPs applied what they believed was a medical risk-based agenda.

### **3.11 Summary**

The analysis of the data identified risk as a dominant theme in the frameworks of decision making used by AMHPs. There was also a strong correlation between the criteria for detention and the consideration of these risk factors. This legal framework was used as a general structure for the findings chapter based on the statutory criteria of the MHA and how the AMHP interpreted the different elements. The consideration of risk factors in relation to the statutory criteria were then considered and finally the critical elements of the AMHP role and the subjective considerations such as capacity/insight and social factors relating to MHAAs. The focus group findings were presented separately and based on the five distinctive themes that were identified.

## **4. INTERVIEW FINDINGS**

### **4.1 Introduction**

In this chapter, I present the different factors that have been identified as shaping and influencing the decision-making of AMHPs in the process of a MHAA.

Eighteen professionals, working as AMHPs, were presented with a common fictitious vignette and prompt questions were asked to explore the process of decision-making in relation to the application of mental health legislation, their professional role and agency culture. The full vignette is included (see appendix 9.2) but, in summary, the vignette included the presentation of concerning behaviours by a man with a known history of mental illness who was living in the community. The information was presented in stages as if it were a referral that the AMHP needed to respond to in actuality and the feeding of further details about the case was, in part, prompted by the AMHP requesting further information. The vignette was tested and refined using a grounded approach and applying knowledge of how referrals develop, supported by themes from the literature.

The interviews were recorded, transcribed and analysed using a thematic approach (King 2010). This method of analysis is discussed in the methodology chapter 4 and was considered appropriate since the identification of a-priori themes based on the literature is a key principle of case study research. The content of the vignette was also guided by the literature in order to ensure that key elements of process identified were included such as legal process, interpretations of mental disorder, considerations of risk and the influence of contextual factors. The interviewees discuss the details of the case as if it was unfolding in real time and I have reported the findings using this approach.

The use of vignettes enabled me to test the critical realist approach I had adopted as I was able to test the two key themes. Firstly, by using a case study that was common to all participants I was able to identify the intransitive features of AMHP decision-making that bounded the work they were doing. Secondly, I was able to compare and contrast these interviews to see how the individual AMHP made sense of the information and situations he/she was presented with, enabling an analysis of the transitive or more interpretive elements of this process.

The evidence is presented thematically the first theme being the legal framework that the AMHP's consider. Secondly the dominance of risk as a consideration in assessments and how the AMHP negotiates their role within this.

## **4.2 The Legal Framework**

The AMHP role is situated within a statutory legal framework which boundaries the work that they do; it was apparent from the data that this took on the form of explicit as well implicit expressions of these legal considerations. The findings here pick up many of the themes of previous research (Glover-Thomas, 2011; Peay, 2003) about the differences and similarities between the legal decisions of AMHPs as compared with other professionals who are legal decision-makers. The connections between emerging themes and the literature will be made at points in the findings and its significance will be discussed in greater detail in the discussion, chapter seven. The evidence is presented in a combined way, the emerging themes are identified, and quotes are used to support these themes and give additional detail.

There was clear evidence that AMHPs were aware that they were working within a legal framework. From the initial referral, AMHPs stated that they had a legal obligation as an AMHP to consider the necessity of an MHAA. Here the AMHP is describing the perception of their initial responsibility under the legislation.

“Well I have been requested to undertake a Mental Health Act assessment, so I have got to consider that. As part of the role generally speaking even in the absence of any other information if I couldn't get hold of anybody, I would feel on the basis of what's there I would have to go out and have a look at the situation” (Participant B1)

The AMHPs were, on occasions, overt about aspects of the law they were considering; for example, there was frequent reference to the least restrictive principle of the MHA. There was also reference to the criteria for detention under the Act and description of the legal duties of the AMHP at various

points in the process. It was the least restrictive principle that was most often named in the AMHPs considerations.

“They kind of like usually around the least restrictive option and based on the assessment of risk where you might find that certainly kind of like health colleagues not always just sometimes are kind of like less willing to, not of a mind set to have the least restrictive option as the ultimate consideration and you know kind of like may just feel that they are opting straight for depriving someone of their liberty regardless.” A1

Other principles were not always explicitly evident in the interviews and the AMHPs did not appear to adhere to a prescriptive process in the assessment based on the principles of the MHA. Although there was evidence throughout that the principles were being adhered to in practice, the AMHP may be describing a principle such as the *purpose and effectiveness* principle but not naming this explicitly.

“I guess you know, again you add to that balance between people’s human rights and deprivation but actually safeguarding article rights you know as well, rights to liberty and security. It’s balancing all that, I think. For some people they do have kind of revolving door patients don’t they, what’s the purpose for that individual really”. D1

The most frequent reference to the law was regarding the criteria for detention, particularly in the interests of the person’s health, safety or with a view to the protection of others. There was also reference to the criteria that the person must be suffering from a mental disorder of a nature and/or degree. This was not always explicitly stated in these legal terms, but the investigation of the person’s mental health history, diagnosis and current presentation indicated that the AMHP was testing if these criteria would be met, even though, in law, the identification of these factors is primarily a role for the medical practitioner.

“You know because the criteria for detaining somebody under the Mental Health Act is, have they got a mental disorder, a nature of degree that requires a period of treatment, you know assessment, treatment in hospital?” K1

The findings suggest that the decisions AMHPs make are not binary in the way that legal decisions are interpreted in court. In other words, the evidential threshold is not based on harm having already occurred with evidence available to prove this. Instead, decisions are more fluid, based on the chaotic, complex and constantly changing situations that practitioners are faced with. The decisions are also being made within the framework of risk which considers past events, current concerns and future possibilities. In this respect, the interviews undertaken would indicate that mental health practitioners consider the law based not only on what has happened previously but based on the potential consequences of their own inaction.

“so I think it’s is often the person’s perspective on it that leads you to Section, you think if I can negotiate something and you’d accept a bit of help we can run with that, but if, the question is if I just leave him is he just going to get worse, there are indicators to say things aren’t going very well for him, that’s the thing for me” O1.

Decisions were primarily focused on the notion of achieving a positive outcome rather than being principally based on explicit legal thresholds such as ‘beyond all reasonable doubt’ or ‘balance of probabilities’ when deciding if someone met the criteria for detention. At the same time implicit in the language is evidence of the weighing and balancing of probabilities. The AMHP considers the evidence and tries to approximate possible outcomes.

“It would tell you that he may say, I will agree to not smoke cannabis, I will agree to work with the community team, I will agree to be prescribed medication and I will let workers into visit and monitoring and attend outpatient appointments but in reality he wouldn’t necessarily follow those agreements when given the option later on.” I1

In the context of a MHAA, it is not just the AMHP who is the decision-maker, and any application must be founded on medical recommendations. The interviews revealed tensions that exist in real practice. For example, AMHPs implied that there could be differences of opinion with other professionals about whether the circumstances of this case warranted an application for detention and intimated that such differences were not uncommon. This is consistent with the expectations of the differing roles

of the AMHP and the medical practitioners within the statutory legal framework. The AMHP here is acknowledging the separate role of the doctor and at the same time expressing their understanding of the role they have in law to act independently of the medical practitioner.

“I have been to places where an applications (medical recommendations) have actually been made out, which is fair enough but that the person has been interviewed by myself and another doctor and it's completely kind of different it's not just about the degree and stuff but yes, so I have had situations where I've gone back to one of the Section 12 Doctors and said we are not going to detain on this occasion, he's engaging with crisis team, co-operating with mental health team, there is risks there but the person is capacitous” D1

The study found that the AMHPs did not necessarily see differences of opinion as problematic and that they viewed the whole procedure as a joint process of assessment and decision-making. The description of joint decision-making also included the recognition that the AMHP and the doctor have differing legal roles.

“I'm aware that they have got to ask their things, they're specifically looking at mental disorder and whether or not they would be making a recommendation so I am aware of that and I don't want to infringe on that too much as well. So it's sometimes what happens if you get a confident doctor they would be very specific about asking that person specific things like are you aware of the time, do you know who you are, do you know what we are doing here that type of thing, so I let them get on with it.” J1

There was also evidence that the AMHP would seek to include doctors who know the person in the interview to bring a unique perspective. This was sometimes a psychiatrist who knew the person's mental health history, or a GP who had previous knowledge of the person. The AMHPs stated that this person would be able to present an alternative view of the person's history that could possibly help to contextualise their behaviour, again this practice is consistent with the guidance in the CoP/MHA.

“So, if I feel like the Doctors are struggling because sometimes, they do, I'm quite happy to take the lead on that and just get the general conversation going. I'm quite happy to jump

in, so I just really try and work out how the dynamics are going to be with the doctors. I would rather the person that knows him best speaks“J1

When scrutinising whether the request being made justified a formal MHAA, there was a recognition they were considering an intrusive process that may lead to someone being deprived of their liberty, reflecting the rights-based approach as described by MacDonald (2010). Therefore, from the beginning the AMHPs appeared to be checking that the person may ultimately meet the criteria for detention, before accepting the necessity of an assessment being undertaken. In the narrative, this appeared as a consideration by the AMHP of whether the person may require detention and then an elimination/confirmation of this option by the sifting of explanations and the exploration of alternatives. One of the issues that the AMHPs raised was the misperception by others of the actual nature and purpose of a formal MHAA. The AMHPs described discussing the request with referrers and establishing with that person, what they were actually requesting. On occasions they identify that it was not an MHAA they were requesting but an assessment of the person's mental health and support for that person with regard to their mental wellbeing.

“One of the things I think about is whether, why has it been bumped up to a Mental Health Act assessment and not just in this job but in my previous job as well we see lots of somewhat preceptor bump ups into Mental Health, so they started down here and gone straight up to their they do not pass go 0 to 60 and so my sort of starting point most of the time on a community one is why is it a Mental Health Act assessment” O1

“I mean the question I have and always have in mind is.... does that person need to be in hospital for their wellbeing, for their safety for a risk assessment? Potentially they will be deprived of their liberty – that is the trigger for a Mental Health Act assessment for me.” D1

Although there was little evidence of explicit reference to case law, CoP/MHA, or the MHA itself, which was consistent across all interviews. There was no indication that the considerations were inconsistent with legal guidance or case law. AMHPs approached the application of the law as an interpretive exercise which is a fluid exercise of constructing facts but within a legal framework. The coding of the decision-making in the evidence grids in the appendix demonstrates that although not

always explicit reference to the law is implicit in the considerations of the AMHP. The various elements of these legal considerations and the frameworks they are considered within are discussed in more detail below.

#### **4.3 Frameworks of Consideration**

The legal framework in a formal sense is determined by statutory legislation, codes of practice and case law. There remains a subjective element to this based on the interpretation of the individual actors, and the frameworks they use to interpret and populate statutory considerations. The way these frameworks are developed have been described in the literature (Strachan & Tallant, 1995; Russo & Shoemaker, 1992; Schon; 1991; O'Sullivan, 2011), how they are developed in AMHP considerations is now described below.

The issue of risk is something that AMHPs consistently referred to in their interviews. It was discussed throughout the information gathering, planning and final decision-making stages of the MHAA. AMHPs regularly talked about the risks the person presents to themselves or others. This was on occasions directly referenced to the MHA, including the consideration of the person's own health, safety or with a view to the protection of others. There was also evidence that the AMHPs were trying to identify if there was a causative nexus between the perceived mental illness and the identified risk.

The prominence of risk as a factor and how this is identified is the initial focus of this next section, which begins with a consideration of the frameworks of assessment that the AMHPs I interviewed, consciously or unconsciously adopted. The evidence from the interviews undertaken was that the considerations of historical and present-day factors are considered simultaneously within the complex dynamic of the current situation which included an eye to the future.

There is evidence here that the MHA and its CoP/MHA have an influence over the criteria that the AMHP includes in their considerations. There is also evidence that these factors are influential in how the AMHP sees their role in relation to others involved in the process and how they consider the purpose of the action that they take. These factors are presented in more detail below.

#### **4.3.1 Considering the Criteria**

The AMHPs did, in all cases, describe risk factors that would lead them to making decisions or discounting options. There were similarities in these factors across all of the interviews as identified in the thematic analysis. There is no evidence that AMHPs referred to factors based on statistical studies of risk factors alone or prescriptive risk assessment tools but there was a consistency to the range of factors that the AMHP wanted information about before making a decision. It was not within the original scope of this research to ask where these factors originated from, or if these factors are based on specific training to be an AMHP, prescriptive risk assessments or practice experience and/or tacit knowledge. There are writers, Bressington et al. (2011); Morriss (2015); Stone (2018), who have identified how similarities in AMHP practice are developed, the origins of a specific knowledge base may be the basis of further research. The way in which the criteria for assessment or detention is scrutinised will now be broken down into some of its component parts.

#### **4.3.2 Criteria: Nature or Degree**

The criteria considered, arising from the MHA are that the person has a mental disorder of a nature and/or degree that warrants their detention in hospital for the purposes of assessing or treating mental disorder. This must be assessed as being in the interest of the person's own health, safety or with a view to the protection of others. The evidence would suggest that the AMHPs start this process by considering issues of concern when deliberating the need for a MHAA and seek to confirm risk factors which may indicate that the statutory criteria are at least present before deciding to undertake the assessment

"There's not a lot of information there so I would be contacting the community team for more information, but on that information on its own there are risk factors straight away as he's a male in his thirties, lives alone sort of stand out. Previous mental health problems and is becoming aggressive, or sounds verbally aggressive anyway towards his neighbours so these are the sorts of things that you could pick out straight away from that" B1

There is consideration of whether there are symptoms of possible mental illness, such as delusional beliefs and paranoid beliefs. The practitioners considered the presence of behaviours or verbal expressions by the person as indicators that they may have a mental disorder. In considering an

assessment, the presence of identifiable features of perceived mental illness was considered important. The question of established diagnosis was also considered.

“He’s got a diagnosis; he’s got a disorder identified whether he agrees with it or not” N1

Behaviours or symptoms were considered as a way of establishing the presence of mental disorder including the expression of the person’s beliefs, their actions or the opinion of others.

“On the face of it, he does sound quite let’s say distressed in terms what’s happening for him but it’s kind of understanding what is it about, what is his behaviour about with shouting at neighbours, you know is it, it might not be mental disorder, but you will probably find out from the team perhaps who knows him, think about his presentation in terms of his degree and the nature of his behaviours you know, so I would be thinking about that really.” D1

#### **4.3.3 Health, Safety & Protection of Others**

When the AMHP is considering detention, they must check that the doctors have justified the person’s detention in relation to their health or safety or with a view to the protection of others, or possibly all three. Evidence that these factors were being considered in relation to the person’s health included the extent to which there was compliance/concordance with mental health professional’s view of their mental health, evidenced by engagement with services and acceptance of ascribed diagnosis. The AMHPs definition of this being non-concordance/compliance included attending appointments or whether the person allowed mental health practitioners to visit. This also included accepting the advice and opinion of professionals, including diagnosis and treatment i.e. was the person taking their medication? Do they have insight? Do they have the capacity to consent to treatment? Behaviours such as substance misuse or refusal to take prescribed medication were also considerations. This adherence to medicalised approaches to mental illness was something Cohen (2016) believed was a trait of all professionals working in mental health. Although there was no evidence in the interviews, I undertook that the person’s previous diagnosis alone was the reason for assessing and subsequently detaining someone. The existence of a previous diagnosis was given consideration but was not the singular reason for deciding a course of action. This was a factor in considering making an application

for section 2 or 3 of the MHA although in all cases this was considered alongside other factors. Here the AMHPs are checking medication concordance/compliance.

“Basically, I suppose looking if he has been taking a mood stabilizer; how much he has been taking; has he been compliant with that” P1

“Is he taking his medication or is he not taking his medication, what medication is he on that sort of thing. Is he outpatients or not outpatients?” B1

“..... is he taking his medication, does that usually help, is that something that has changed for him, is he using cannabis, it still doesn't really say that but I think that kind of, around medication and things like that...?” G1

Regarding the person's own safety, the considerations identified included expressions of suicidal thoughts and suicidal actions, self-harm and the possibility of retaliatory behaviour from others arising from the person's behaviour. There was also consideration given to unintentional harm as a consequence of the person's behaviour such as recklessness or inattentiveness when driving. The protection of others encompassed intentional violence and aggression towards others, verbal confrontation, hostility and volatility towards others. The protection of others also contained unintentional and consequential harm to others, particularly harm to family members or neighbours who regularly experienced the person's hostility, volatility or distress.

“The risks that it highlights are obviously with the suicide attempt... [this] is the most obvious screaming risk really, there is the risk around his so called anti-social behaviour, sounds a bit convoluted but if somebody is behaving in way that is volatile towards other people, sometimes those people can be volatile back, and so it's not just a risk for those people he's behaving like that to, it's also what they could do back to him” G1

There was no evidence on first analysis that AMHPs were assessing, based on abstract or actuarial risk factors alone such as diagnosis and there were no overt references to AMHP beliefs about statistical factors not linked directly to the individual's history or the current circumstances. There were however consistent factors that the AMHP would seek confirmation of before proceeding to a decision. These factors are related to the MHA and include the presence of mental disorder, risk to self or others and the necessity of approaching any decision for intervention using the *least restrictive and maximising independence* principle and other principles in the CoP/MHA. The different elements of risk assessment identified by writers such as Menon (2013) are apparent in these discussions. The consideration of mental disorder, health safety and protection of others and how these were considered and weighted is looked at in more detail in the next section

#### **4.3.4 Current Concerns**

The factors of concern were consistent across the interviews. Another consistent feature was that these factors included additional time dimensions. The factors were considered in terms of past, present and future. The AMHPs repeatedly asked about the current presenting symptoms or behaviours that make it necessary to assess this person in the present; additional factors were then scrutinised as part of the consideration. The person's current presentation and diagnostic history appear to have additional weighting if there is something in the person's current presentation that could be matched to previous episodes when the person has been unwell.

“They’ve got background information of this person, they’ve got a measure, they’ve seen this person previously so can measure against how he is now, and they can compare risks. They can also engage with them, if a person sees a friendly person that’s always a lot better.”  
H1

The AMHPs interviewed looked at the person's current behaviour and tried to match it against their previous behaviour to establish any patterns or possible indicators of current risk. The information was given additional weighting depending on where the information had come from, if the information was from family who had a long-term relationship with the person this was perceived as

being of higher quality information as a possible match could be made between current and previous presentations.

“I think in terms of risk in terms of family’s knowledge of him because the systemic assessment is obviously about family’s views, opinions and beliefs. They know that individual well, it sounds though that this chap’s quite distressed, it sounds that his behaviours affecting the family, the system they are worried, you know so I think it would be appropriate to, at that point, you know when you have collated information in terms of his history, collating information from the community mental health team. There seems to be a pattern of kind of relapse indicators that his wife has clearly identified. Yes, I think it would be about mobilising a Mental Health Act assessment at that point” D1

A consistent feature across the interviews was that the AMHPs wanted to know what it was about the current presentation that was of concern to others. They also questioned if the behaviours, beliefs and actions that were being described, were indicative of a mental illness or whether they could be otherwise explained. In other words, the behaviours may be of concern, but does this mean they are a manifestation of mental illness, or are they reactive behavioural responses that could be situational and wrongly perceived as mental illness?

“.... we see family breakdown of relationships, whether that be because of mental health or because of choice, he might not have had long term. So, it talks about 11 months ago it would be interesting to know what his thoughts are recently. What’s going on recently you know, still doesn’t talk about function again just day to day – yes, we’ve talked about previous drug use, but it’s what happening here and now really. We talked a lot of historical area of stuff but what’s going on now” H1

This counter-intuitive approach was consistent across the interviews. The AMHP begins by taking initial referral information which includes “why now?”, and then begins to construct an overall picture using a framework to make sense of the concerns. The framework includes similar areas for each AMHP, as in the example above. This evidence is then considered in terms of what it may mean historically for this individual in a process of forensic examination. In other words, what is it about the

person's current behaviour or presentation, when matched against their previous history, which should lead the AMHP to be concerned or otherwise?

"Yes definitely, if they said he can rapidly deteriorate, he can be fine for ages then bosh really rapidly deteriorate, and when that happens quickly, in the past he's quickly made an attempt on his life, I would be trying to like get it going as quickly as possible you know." J1

"This is about the anti-social behaviour, I guess I'm picking it a little bit, it makes you wonder with that and the shouting and things now are these past issues in relation to his beliefs and when he's been unwell or is this part of who he been kind of longer term and outside of the illness." F1

It was not uncommon for the AMHPs to pick out a behaviour or concern and explain why it might indicate risk and then turn it on its head by presenting a counter-intuitive explanation. This process was revisited at different stages of the assessment and there was evidence that the AMHPs would give different weighting to the concerns of others, depending upon the length of time they had known the person, their relation to the person and possible motivations and explanations for their viewpoint. This was also part of the method they used to identify a causative nexus between the person's behaviour and perceived mental illness. Another element to this was the questioning of the necessity of detention in hospital even if the person was presenting with mental illness. The AMHPs questioned what harm was actually occurring rather than just focusing on perceived risks.

"That information that you have just given me wouldn't automatically makes me think he's mentally unwell. That might be a set of circumstances that is actually correct..... Or misread by him, but not because of him being mentally ill. The housing association, he is in a house that is too big for his needs and they want him out." L1

"He might not be wrong; his ex-wife might be trying to go in the house and change the locks.... he might have a cupboard full of things, he might be looking forward to his kids coming back, and he might not mention the illuminati when the kids are there .....

You know you can't just assume it's all paranoia, it could be paranoia but I've got kids, they take things they move things, so I'm not damning him at all at this point, I'm thinking ok so I'm still gathering information". (H1)

The data suggests that the AMHP is trying to place current concerns in context and differentiate between perceived risk and the actual risk of something harmful happening to the individual or others. The AMHP is cross referencing current risks with past events and testing the quality of the information by asking about the possible explanations for the information being provided by different actors. This is an active conscious process of creating and deconstructing frameworks which links to the description Schon (1991) proposes is the hallmark of professional decision-making. In the section below, I discuss the framework tools AMHPs use to consider the factors identified above and explore these in a way that is personalised, contextualised and current.

#### **4.3.5 Complex Decision-making**

The decision-making of the AMHPs was framed by legal considerations that the AMHP populated in terms of the individual factors relevant to the particular case. This was a process of increasingly complex decision-making that built on historical or static factors and current concerns. The AMHP then tests the evidence against a framework or frameworks of understanding that they were constructing and deconstructing to make sense of the situation to enable them to make a decision. There were various elements of this evident across the interviews. The AMHP uses various tools in this process including the matching process where the AMHP uses their previous experience of assessments as a template for making sense of a piece of information, it also includes the use of the counter-intuitive method of deconstructing a particular view. In addition, the AMHP considers three time dimensions relating to the concern, historical, current or future and also the weighting of evidence depending on the source of that information and its perceived validity. This process progresses through the synthesising of this information into a hypothesis which gives the AMHP a degree of confidence in predicting future outcomes. This begins with a rapid gathering of facts before progressing to more complex processing of the information.

“Right – he’s given a lot more information there; I think to me it feels that he’s not well at all. I think the kind of persecutory type thoughts that he’s having are very prevalent – I would kind of want to know what he plans to do with that information, I would want to know what his next steps are, because the concerns that people are bringing up and the things that he’s saying, is he going to act on anything, especially since people have said about anti-social behaviour, the neighbours and things like that the police having anti-social behaviour order I seem to remember. It doesn’t seem right to me that he has the lack of engagement with the mental health services as well that’s causing me more concerns as well, is he taking his medication, does that usually help, is that something that has changed for him, is he using cannabis” G1

As part of this process the time dimension was evident and the AMHP was either asking for historical information or questioning what relevance historical events had in the current situation.

“When was the last time that we knew for definite that he was taking his medication and perhaps even when was the last time that his mental health was good or stable, and whether that’s been a quick deterioration or a slow deterioration” R1

“It’s the risks, have they determined if we have a mental disorder and then obviously if it is determined that he has a mental disorder, determine that he has past history of relapses and being detained and then from there on in we are looking at diagnosis then aren’t we I suppose for some reason but you have to look at the bigger picture as well. What’s happening within the family as well? It may well be the stress of the wife leaving him as well, is he not functioning well” E1

“What’s going on recently you know, still doesn’t talk about function again just day to day – yes, we’ve talked about previous drug use, but it’s what happening here and now really. We talked a lot of historical area of stuff but what’s going on now and what’s happening, when was the last time CMHT saw him, what led him up to this request for a Mental Health Act assessment, has the CMHT tried to work with him” H1

The matching process starts with the AMHP identifying that the current scenario has similarities with previous assessment considerations and matching elements of the presenting circumstances with previous experiences. This included examples of the AMHP matching similarities and differences in the situation they are presented with and also discussing previous outcomes of decisions made. This process is then used as a possible guide to outcomes in this situation. In this quote the AMHP is explaining why they might be cautious about proceeding to assessment or detention.

“I have been involved in situations where someone’s not been distressed but been a little bit odd or difficult and people have wanted to use the Mental Health Act at that sort of lower level and that’s when the community alternatives or less than an admission to hospital might be more of a viable option, and the younger someone is I think, that indicates it. The older you get the more you ‘ve been through the system the more the system swallows you up”

B1

The findings showed that AMHPs used this matching process to create a framework to begin the process of understanding the situation. This framework was scrutinised to see if there was evidence of risk, but that matching was not simply to create a binding precedent. The AMHPs also used their previous experience as a cautionary tale. The general message being, ‘I have seen similar situations before, and they had a negative outcome because a counter-intuitive approach was not taken’. It was evident that the AMHP was matching the person’s current behaviours against previous scenarios and asking various questions including were these behaviours indicators of mental illness or possible predictors of associated harm. The AMHPs looked to see if the behaviours were indicators of mental health relapse and where they believed this to be the case, they further questioned whether harm had actually occurred or if detention had been necessary.

“I suppose experience tells me that most people that have experienced of seeing (hallucinations) while they are being delusional there is always some truth at the bottom of those delusions. I remember going on an assessment of a lady who was talking about she was being watched by the IRA and she taped up all the windows and all the doors and wouldn’t let anybody in and she was sectioned and she did need treatment, but the basis of

her delusions was right – her brother was part of the IRA so there can always be some real happenings even within someone’s delusional state.” R1

“I went on a case the other week where a similar scenario had come up .....It was good actually as I went out, I went to see this chap in the end, knocked on his door,..... his house was ok, it was manageable, stuffed with food in the kitchen, he was acknowledging that he had been unwell but we managed to keep the situation basically stable without going to a full Mental Health Act assessment and arranging a hospital admission” K1.

As the assessment progresses, the process moves through various stages of gathering information and concerns, theorising and hypothesising about the information that is presenting. By selecting, considering and constructing frameworks, the AMHP builds an overall picture. This picture continues to change as different information is added and discarded. It is also weighted in its importance and continuously tested. Current evidence is given greater weight than historical evidence. Verifiable evidence is given greater consideration than hearsay and the AMHPs also consider “expert” evidence which includes professionals, family and the person themselves. All this evidence is then considered within the crucible of the decision-making process, which is the formal MHAA with the person concerned present. The ultimate goal is as Szmulker (2018) critically describes; is to use the past and present to predict the future and manage risk in the here and now.

The AMHP combines many of the elements of the actuarial and forensic approaches but describes a more dynamic process of information gathering, risk assessing, planning and reviewing, which is individualised based on the service user’s story, current situation and desired outcomes. This dynamic constantly changed as live information was fed into the assessment process from others who had more knowledge and direct contact with the person.

“I would expect to get all that information electronically or with the people that directly work with him.” R1

“I went on a case the other week where a similar scenario had come up to be honest a Mental Health Act assessment had come in from one of the community teams but was busy moving office the care coordinator had been on leave a little bit, they were busy and ended up coming in” K1

“I dealt with something like that the other day where the person who was being assessed blamed his partner for speaking to services, and he had that in his mind, and it held him back from telling us stuff, so I would be cautious of that. But I would still bear in mind what she said you know that she doesn’t think he’s that bad, but I would still be taking it for what it is and thinking that we could speak to someone else as well” J1

The evidence from the interviews undertaken was that actuarial factors and forensic factors are considered simultaneously within the complex dynamic of the current situation in similar ways described in the literature (MacDonald, 2010; Menon, 2013). Although the evidence here was that there is no separation or distinction that demarks the use of one model or another. What can be said is that there is a framework, or frameworks, of understanding that the AMHP constructs. This appears to be multifactorial and underpinned by general areas of concern the AMHP considers important. These areas are then populated with risk information that is historical or current and considered simultaneously or dialectically. This quote shows this multifactorial approach and the search for the least restrictive option embedded in it.

“Suppose the options we’ve got are that he said he thinks mental health services are in league with housing in everything, is there any way we can assure him that there not...would he re-engage with community services, has he been taking any medication, has he been receiving any kind of support, is there anybody in particular he trusts..... If he continues to say there is nothing wrong and that he’s not going to engage with anybody....., his mum says that he’s not looking after himself, is this somebody who is not preparing himself 3 meals a day or are we looking at somebody who’s kind of seriously unkempt and the house smells and he’s not coping you all those kind of things. Has his body language relaxed at all, do we need to think about whether he definitely needs to be in hospital or not? .....will he re-engage with the community team, has it gone beyond that, there’s a lot of beliefs going on that mean that things could get quite a bit worse, does he need a period of assessment

in hospital. If he does need a period of assessment in hospital can he go informally, still bearing in mind we haven't got any beds. If he won't go in informally then obviously there's the option of detaining him but that's the last-ditch option" Q1.

These concerns are triaged using past precedence for the AMHP or the individual. This presents as a dynamic process throughout but culminates in the ultimate test of these hypotheses in the face to face interview and process of elimination or confirmation. This is not an isolated task undertaken by the AMHP, but a collaborative process which begins with consultation with other professionals and family. It ends with consultation and collaboration with the person being assessed and can move back to consultation with other professionals and family. This is not an abstract process of eliminating and confirming beliefs but is the creation and consideration of options in real time.

"I want to know as much information as I can possibly get, I often find that I will get a lead, get a number, I often describe it as you get given a few pieces of the puzzle at the beginning of the day and then random and on part of that piece of the puzzle you will get given a phone number or a name and you phone that person and they will give you a little bit more of the puzzle and that will lead you to another phone number or another name and you find out who that is and you phone them and throughout the day you get a number of different pieces and by the end of it you've got all the pieces and they are all on the floor in front of you and you've got to sort of work out what the picture is for yourself. You know what everybody else is saying within their own little pieces but to put it together as one big picture I have got to do that for myself at the end. "J1

"I see my job more about a more of a holistic way of looking at people and whether the risks are there for us to take action. What I would like to know is comparatively, is this him at his worst or is this leading up to something that could be quite dangerous for him or for somebody else or is this kind of him plateauing a bit or not, because everybody is different. People can have persecutory thoughts and not act on them basically; is he looking after himself, is he eating like his mum says, she doesn't think that he is. If he's not eating or drinking properly things are going to deteriorate for him." G1

In this section I have looked at the legal framework the AMHPs work within and how this boundaries their decision-making. This includes the frameworks or tools that the AMHP uses to consider the factors that the AMHP is presented with. This has already highlighted the prominence of risk in the AMHP's considerations in the next sections. I will look in more detail at the consideration of risk frameworks and some of the risk concerns used to construct these.

#### **4.4 Defining Risk**

The MHA does not use the term risk but refers to compulsory detention being necessary in the interests of a person's health, safety or with a view to the protection of others. The AMHPs consider these areas generally but tend to use the term risk to define what they perceive these categories entail. The reason for the dominance of the risk agenda is alluded to by a number of writers (Ramon, 2005; Szmukler 2018; Warner, J et al. (2017), the evidence in this chapter relates primarily to the consideration of risk concerns. There was no evidence of the AMHPs overtly adopting a definition of risk using a prescriptive risk assessment tool or named theoretical framework. When the interviews were scrutinised, it was apparent that the AMHPs were identifying similar factors as issues of concern or risk and that these fell broadly within the criteria for detention under the MHA.

In relation to the person's own health, this was defined in two ways, firstly a direct risk to the person's physical health i.e. self-neglect. This also included the identification of a causative nexus or ensuring that the behaviour arose because of the person's mental disorder or is a manifestation of the disorder. This included not eating due to delusional beliefs, self-harm arising from distress or physical harm arising from erratic or risky behaviour.

"so then it's about risk to self you've got I suppose the other thing as well the other factors and indicators that I am looking to the doctor to be talking about - appetite, sleep, self-neglect those kind of things about risk to self, he's headed that way, that its risk to self and then of course the suicidal ideation and (associated) thoughts, plans and intent and then less so at this stage risk to others" N1

"He is paranoid; there's potentially other people at risk, he's potentially at risk because it's self-neglect - there is evidence of that. His mental health would likely to deteriorate further

if he incorporated all these individuals into his belief system, based on some view that he is different” L1

The second notion of risk relating to health was the continued deterioration in the person’s mental health if the person does not receive care or treatment. In other words, the risk is that the person’s mental distress will continue or get worse if not addressed. This concept sees mental health itself as a health category. The AMHPs sought evidence of this in the form of symptoms such as delusional or paranoid beliefs, psychosis, low mood or elevated mood.

“The hope is that they are able to support him to having his mental health stabilised enough for him to be able to go home and be safe in doing so, preventing him being detained again.”  
G1

“or risk to health isn’t it basically the presentation as such that they are on that downward slope and they are not going to stop so they are going to get to the point where they’re self-neglecting or that there will be sufficient risk to health and he becomes a risk to himself, and how many hours do you wait, it’s a judgement call” O1

When considering the person’s own safety or risk to self, this also has several strands. This can include self-harm or suicide where the person actively and intentionally harms themselves.

“So yes, I have got more than enough to go, I think the risk factor is the thing, at the moment if I’m still sat at my desk the thing that jumps out off the page for me is the risk, suicide risk actually because that’s the most overt” O1

Secondly, risk relating to the person’s safety, crosses over with some of the issues relating to risk to health, in that harm to the person may be because of the person’s mental ill health but the harm is not an intentional consequence. This includes the harm that may arise from someone else’s retaliatory behaviour. The person may behave in ways towards others that evoke a negative or possible violent

response. It is also described as the erratic or risky behaviours that arise from someone's delusional beliefs, such as sleeping rough to avoid detection from those the person thinks is seeking to harm them. The risk to self may also include social factors such as the person losing their tenancy, relationship breakdown and carer breakdown.

"On the other side of things if he is scared, he could run away and we might not find him, he could have put himself at severe risk" Q1

"let's assume that he doesn't want to fall out with his wife and threaten his neighbours then actually if we can stop that by putting him in hospital for a bit then maybe we ought to" O1

Regarding the protection of others, there are different elements that are being considered. There is the consideration of the necessity to protect others from intentional harm which may include physical aggression, verbal aggressive or other acts against a person. These considerations appear to primarily arise from the person's delusional beliefs about others and the concern that the person will harm others as an act of retaliation, or as an act of self-defence if they believe others may seek to cause them harm.

"I think my fear now with this is that would he hurt himself or somebody else given these beliefs. Would he hurt his wife because he feels that she's having an affair, in order to protect his children would he go for the estate manager, you know because he thinks he's having an affair with his wife, so these are the risks I would now be considering" M1

There is also consideration given to the harm that others may experience as an unintentional consequence of the behaviour or as a by-product of the person's distress. This may be the stress that carers are experiencing from caring for someone having a mental health crisis or the distress that the person's behaviour is causing to vulnerable others in particular children; this may also include the neglect of others.

“I would like to know, even though his sons aren’t living with him they are both kids still, it would like have a bit of impact on them really..... what’s the impact in terms of the dad, because again it’s another thing about is this is an illness presentation and you would be surprised if it has not impacted on his kids, bound to isn’t it” O1

AMHPs consider risks to others to include direct physical harm arising from the person’s beliefs, psychological harm arising from the impact of the person’s presentation on others and harm that may occur during a retaliatory confrontation. The identification of risk concerns was also present during the consideration of how the assessment was undertaken. This included the timing of the assessment based on whether the AMHP thought there was an urgent necessity due to direct risk of harm to self or others. There was also an acknowledgement that the assessment itself could exacerbate risk including risk to the assessing team.

“Well risk to self and others, whether you know whether the person has a history of violence and aggression especially when unwell. Whether they are still currently, I know they have used substances but are they currently still using substances. You know kind of like a history of risk to self I know there is a history of suicide. Whether our presence would kind of like you know bring about or intensify any other risks that he has historically posed to self and others. And also, whether he would actually like lock the door.” A1

The prominent factors that were consistent across the interviews were risk to self or others. The person’s risk history and current risks about suicide or harm to others and their current presenting beliefs and behaviours were crucial in the decision about timing of any intervention, but also in determining how the assessment would be mobilised. These factors included maintaining the element of surprise and ensuring they gained access to the person, including considerations about securing police attendance. The risk being considered here was the risk of the person absconding from the assessment or presenting a direct threat to the assessors.

“Yes definitely, if they said he can rapidly deteriorate, he can be fine for ages then bosh (colloquium for suddenly) really rapidly deteriorate, and when that happens quickly, in the past he’s quickly made an attempt on his life, I would be trying to like get it going as quickly

as possible you know. Even it was a slow deterioration he hasn't been seen for a long time, and there has already been a build-up so I would still be concerned about it". J1

The AMHPs defined risk broadly within the criteria of the MHA in terms of health, safety and with the view to the protection of others. The definition of these risks is broad and includes harm arising from direct intentional acts, as well as vicarious harm associated with the person's behaviour and presentation. These elements of risk were considered throughout the process. They were present during the consideration of whether an MHAA should be undertaken. Historical as well as current issues informed whether the criteria for detention under the MHA were met. These themes are reflective of themes in the literature (Glover-Thomas, 2011; Peay, 2003) and their relevance is considered in the discussion chapter 7. The considerations were across the spectrum including health, safety and protection of others. The weighing and weighting of these factors is considered in the next section.

#### **4.4.1 Calculating Risk**

The evidence would suggest that risk calculation is an open-ended construct that is interpreted by AMHPs using their previous experience and professional judgement applied to live situations. Similar to the description of Osmo and Landau (2010) who describe decision-making as an art practiced in the here and now. This included an initial gathering of information about concerns and then a decision about undertaking a MHAA, at a point at which the AMHP had accumulated enough concerns about risk to decide that a further assessment needed to take place. One AMHP decided at a very early stage that they had enough information, almost at the point of receiving the initial referral. This was based on the information received but, more importantly, who had referred the person.

"I think I would definitely be going out to do an assessment because it sounds as if the individual is experiencing some issues and if I spoke to the CPN or social worker and they feel he needs to be assessed to determine whether he does need to be in hospital or anything else because for me it's about assessing a person's needs and deciding what the

care plan needs to look like to meet that need whether it be an admission to hospital or some other aftercare, or care” C1

The majority of the AMHPs made the decision to undertake a formal assessment after they had gathered concerns from a range of sources. A common theme throughout, was that the AMHP would give greater weighting to certain sources of information. After the initial referral, the community team were usually the first point of contact for the AMHP although for some the family were first to be contacted. There appeared to be a greater confidence in the information or opinion that came from other professionals, although there was still a testing of the information both in terms of what were the general concerns about this person and why but also why was this of immediate concern. The AMHP wanted to know about recent contact with services to establish current concerns, they often wanted to include practitioners who knew the person in order to calibrate the decision-making by incorporating the perspective from someone who has prior knowledge of them. The construction or estimation of risk inherent in the situation is individual to the AMHP but does contain similar factors and dimensions of time including past, present and future. The scrutinising of the quality of the information involved using a range of methods of inquiry such as the counter-intuitive approach mentioned earlier.

“because he has not been seen by his care co-ordinator or somebody by the team at CMHT, so my point of view they know him best why has he not been seen, and why are the family asking for this so I have an issue with that, and know we are all stretched for resources but I think why has he not been seen, can he be seen by someone from the CMHT and should he because there is no immediate risk that says we really need to be out” K1

The AMHPs made their assessments based on their own measurement or approximation of risk. The counterintuitive approach taken by the AMHPs would support this contention, as they considered the presenting behaviour or beliefs and then tested whether the explanations given were reasonable evidence of mental disorder and associated risk. Even when the information suggested that certain behaviours were evidence of mental illness, they further questioned whether this behaviour presented a risk and whether this was perceived or actual.

“It depends what he’s saying, it sounds to me like a psychosis to a degree but what are the risks for this man, he might have been to the shops, he might have a cupboard full of things, he might be looking forward to his kids coming back, he might not mention the illuminati when the kids are there. I would want to ask him about his relationship with his kids, it’s around his functioning” H1

“It depends on circumstances; I think for me it would depend on the level of risk, that person is posing to themselves and others. And it would be a very kind of systemic perspective as well because you know it’s not just about our crisis team but just how the impact that that person having a mental disorder going to have his kids for instance, if they are staying at weekends. Is the other kind of informal support around that person” D1

In terms of risk thresholds that AMHPs were working to, there was nothing explicit in the language used about specific thresholds of evidence such as ‘beyond reasonable doubt’ or ‘the balance of probabilities’ although there was evidence that the process of weighing and balancing evidence was going on, with a view to estimating possible or probable outcomes. There was no evidence of the AMHP explicitly applying a specific test of reasonable fortitude, although they are trying to estimate the possibility of harmful outcomes. These discussions reflect the issues raised by various writers in the literature (Glover-Thomas, 2011; Peay, 2003; Szmukler, 2018) the estimations of risk are made often without reference to the actual occurrence of harm, although the AMHP attempts to foresee what may happen in the future. The AMHPs weigh concerns and build in the possibility of harm occurring based on historical factors and concerns inherent in the current presentation.

“Also got to weigh in the back of my mind that we’ve been told by people that he might go somewhere far away and we might not find him, so has he done this in the past” M1

“I think as the picture unfolds I think people would be concerned because he has got a mental disorder it’s of such a degree its having an impact on his day to day living sounds like he’s getting more and more paranoid he is becoming more and more unwell, whilst the risk don’t seem, there is risks it does seem like they are building up and building up and that people that’s around him could be at risk, especially if he thinks some kind of conspiracy and

they are out to get him he's going to challenge people and there's going to be risks to him and there's risks to other people" P1

The risk concerns often changed over the course of the assessment process. In the decision to undertake an assessment, risk to others did feature strongly in the first instance this included risk to family members and to those who had a caring role. This risk primarily focused on unintentional harm caused by the stressors of caring for the person or the negative impact the person's behaviour might have on the children. The risk of direct harm to others did not feature as strongly in the initial stages, as the risks were considered to be primarily historic. As the assessment progressed, the focus shifted towards the direct risk of harm to others as the nature and content of the person's delusions became apparent. The concern became that the person may harm others through acting upon current delusional beliefs. The existence of paranoid beliefs whose content included the belief that others were out to cause the person harm were a major concern. The primary concern being that they may act upon their beliefs and harm someone else as an act of fear or retribution. There was also a concern that, in the process of challenging others about their perceived actions, others may harm the person in retaliation.

"If there's an immediate risk identified, to self or to others, that would prompt a faster response" B1

"The risk to others would be the extent to which he may wish to act physically or verbally on the paranoid thoughts he'd been experiencing" A1

"If he is being argumentative to the neighbours and other people that you know could be a risk of retaliation as well if we felt that the risks were getting higher and you know his mental health had deteriorated significantly then we would look at a Mental Health Act assessment." I1

Although there was no indication that the AMHPs were applying a conscious theoretical model of risk assessment or that they were using a particular assessment tool when considering risk factors or legal thresholds such as a reasonable fortitude test. There was evidence that the factors they considered

were consistent with the MHA criteria. These criteria alone being present was not enough to justify detention, but it did provide a framework for decision-making. The AMHP uses their judgement to identify what factors are of concern and what can be dismissed. This includes deciding what factors or accumulation of factors meets the criteria for the use of compulsory powers. One of the themes that's apparent is the time dimensions, an example of this being historical context in terms of clinical history. This is discussed in the next section.

#### **4.4.2 Clinical History as a Risk Indicator**

Clinical history featured throughout the assessment process. This was a factor in relation to the decision to assess under the MHA, how the assessment would be conducted and in relation to outcome and the elimination of options. For example, if the person previously harmed themselves or others, then this was regarded as increasing the risk of this happening again, even if it had not happened during the current episode. Clinical history was also used as a way of identifying early on if the person could meet the criteria for detention before deciding to arrange a formal assessment. The consideration of clinical history was used to confirm if there was an existing diagnosis with associated harm and if there were concerns that matched the current presentation.

“There's a diagnosis, he's been in hospital for periods of assessment, been assessed by clinicians who've given him a diagnosis so there is potential there for a link to a mental disorder and concern around his recent behaviour, he's not accepting the diagnosis, a lot of people don't” J1

“The guy is known to mental health services, has been known to mental health services for 10 years, he has had admissions previously to hospital. He does have a diagnosis of Bipolar, probably other related conditions that haven't been assessed yet but that might be the purpose of detaining him and assessing him” C1

There was a consistent theme of the AMHP asking about previous diagnosis. The issue of previous diagnosis is considered by (Glover-Thomas, 2011; Hatfield; 2008; Furminger and Webber, 2009) in relation to a key consideration although other writers (Hall, 2017; Morriss, 2015) identified the belief

amongst AMHPs that this was more of a medical practitioner's concern, reflected in their responsibilities and practice. The interviews would support the contention that pre-existing diagnosis and symptoms have a determining influence on the decision to undertake an assessment but less of an influence in relation to the decision to detain, as a range of other contextual factors were also considered in addition to previous history. These factors may include substance misuse, symptoms or other manifestations of mental disorder such as self-neglect, sleep deprivation or suicidality.

"He's got a diagnosis, he's got a disorder identified whether he agrees with it or not he's erm whether its arising from his substance use or not, he's seems to be voicing symptoms of that disorder doesn't he,..... so although some of these thoughts and ideas could be coming out as a result of his cannabis use, becoming paranoid and psychotic because of that its arising because of that. ....So then it's about risk to self you've got I suppose the other thing as well the other factors and indicators that I am looking to the doctor to be talking about appetite, sleep self-neglect those kind of things about risk to self, he's headed that way, that its risk self and then of course the suicidal ideation and thoughts plans and intent and then less so at this stage risk to others" N1

"It just talks about medical stuff really and a diagnosis the medical model of accepting a diagnosis so to me it's irrelevant really in a sense of how is this man is managing, how he's functioning, what he is doing day to day" H1

The interviews would suggest that previous diagnostic history associated with risk to others does increase the likelihood of an assessment taking place and that assessment may possibly take place in a contentious atmosphere, which the AMHPs acknowledged could in itself create a greater likelihood of detention because of the tensions created. An example of this would be the involvement of the police. The AMHP wants to keep the assessment process contained and safe at the same time they acknowledge that the presence of the police may adversely affect the person, leading to agitation or confrontation, which is more likely to lead to the person being detained. Something the AMHP sought to avoid.

“And I don’t want to be left in a volatile situation and neither is it fair for that person because at that point if they know they’re going into hospital that’s when things can either calm down very quickly or escalate very quickly when the decision is made so I would be considering that. If he’s been quite volatile in the past, I wouldn’t necessarily be thinking I need the police, but I would certainly be thinking I’m going to get my timing a bit better here”. H1

This difficulty could be compounded if there was a history of absconding from assessments or if there was a history of violence or aggression, particularly towards mental health professionals. This also meant there was also a greater likelihood that the person would not be informed of the assessment or the police would be involved in the assessment. There was an expressed belief that the involvement of the police and the way in which an assessment is conducted can be a factor that negatively influences the outcome of the assessment increasing the likelihood of detention. Overall, police involvement was viewed as undesirable because of the stigma this brought to the process and the possibility that this would escalate the person’s anxieties and lead to a negative outcome for him. The involvement of the police was only considered necessary if the AMHP thought there was a strong possibility of aggression, violence or the person absconding.

“....because there’s all these people who have gone round and appeared on him and he’s frightened he’s saying he’s going to run off so I think I would still on balance go in and assess that risk myself I would go and say look this has happened in the past I don’t want to have police coming etc. but can we come in and speak to you, so I would do that” P1

“Because that’s happened in the past I would contact police and make police aware that these incidents happened on the ward this gentleman’s mental health is deteriorating so we don’t know what we’re going to find when we get there so make them aware asking if they can be in the area if we need them. I think I would still be tempted to go in and speak to him even though you need to take into consideration that risk in his history for him it would be so awful ..... “LM

“There are a number of things I suppose the information from that there is a history of physical aggression towards healthcare professionals would suggest to me that that’s a possible scenario again that maybe we do need the police backup for that.” A1

Clinical history of risk was also considered in relation to the person’s willingness to engage. AMHPs use the terms ‘compliant’ or ‘concordant’ to describe the person’s willingness to accept help and engage with a treatment plan. These factors were considered when ruling in and ruling out how the least restrictive or other principles could be applied. As discussed previously, the application of these principles is both explicit and implicit.

“I would want to know that if him missing appointments is a factor in his relapse signature”  
N1

‘.....there is a certain history of risk in relation to you know his mental health as well, risk to self-harm and risk to others but that’s historical, the current issues are non-engagement non-concordance possibly, the children visiting when you know people have suggested concerns.’ A1

There was no data from the interviews that suggested the AMHPs were willing to make an application for detention purely on the grounds of the nature of the person’s diagnosis or clinical history. In other words, the mere presence of a pre-existing diagnosis was not enough. The pre-existing diagnosis of mental illness, defined in the MHA as the nature of a disorder, could be deemed enough, in law, to warrant an intervention against someone’s will, despite there being no acute symptoms at the time of assessment (Jones, 2019). This reason alone for detention was not evident in these interviews. Although, the nature of the person’s diagnosis and the previous symptoms was a consideration and was matched against current behaviours as confirming a diagnosis or presence of risk.

The AMHPs did consider past behaviour as a possible predictor of current risk although this was considered alongside contextual factors such as substance misuse. There was no evidence to support the view that the pre-determination of a decision about detention was apparent at the beginning of

the process based on pre-existing diagnosis, but there was evidence, as mentioned before, that this played a role in the decision about the use of section 2 or section 3 of the MHA at the end of the assessment. The method of considering additional contextual factors raises issues identified by various writers (Glover-Thomas, 2011; Menon, 2013; Peay, 2003). The accuracy or efficacy of this approach is questioned by other writers, (Pilgrim, 2014; Ramon, 2005; Szmukler, 2018; Warner et al., 2017), although the presence of substance misuse does appear to be accepted as a general factor that creates additional risk.

These findings suggest that pre-existing diagnosis is a factor in the decision of the AMHP to assess under the MHA and that, in the first instance, the AMHPs ask a range of questions about the person's diagnosis and clinical history that evidences risk of harm. The evidence would suggest clinical history is an important question but not the key determinant in making the decision about whether to assess or certainly whether to detain if the person is assessed under the MHA. The interplay between the AMHPs consideration of these factors and the relationship with other parties in the process is considered in the next section.

#### **4.5 Roles and Accountability**

The dynamics of risk and the accountability associated with the assessment, also have an effect on the decision-making of the AMHP. AMHPs are explicit about the consideration of the risk the person poses to themselves or others, as part of their role within the legal framework and its criteria. Another dynamic included the risk concerns of others that do not necessarily concur with the view of the AMHP. These concerns potentially arise from several sources including family members or other professionals. Differences of opinion with those requesting assessments included professionals in community mental health teams about necessity or immediacy of an MHAA. This took the form of AMHPs expressing their beliefs about what other practitioners should have done before requesting a formal assessment. AMHPs expressed the belief that there should have been more consideration of less restrictive alternatives to assessment or detention i.e. proactive engagement by the person's community team or home-based treatment. The AMHPs perceived that there were occasions when the decision to move to a formal assessment was driven by other agencies or professionals not understanding the law or being too quick to consider detention or not considering the impact on the

person of being deprived of their liberty. Reflected within these concerns from the AMHP is their perception that upholding the principles of the legislation is part of their role. This may be explicitly named as the least *restrictive principle* or implicit in the way the AMHP questions the purpose of the request.

“Most of the time I think with health colleagues that there is a shared understanding, but conflicts do occur and I’m happy to say that kind of like they are not incredibly common, but they do occur. They kind of like usually around the least restrictive option and based on the assessment of risk where you might find that certainly kind of like health colleagues not always just sometimes are kind of like less willing to, not of a mind set to have the least restrictive option as the ultimate consideration and you know kind of like may just feel that they are opting straight for depriving someone of their liberty regardless” A1

“I asked him to be really clear about his rationale and when he did and when we investigated it and when we spoke to the residential home, they said that they couldn’t have her back because of the risks that she was posing, which then meant that there was no community solution, but I wasn’t just going to say yes admit her” Q1

Generally, the AMHPs expressed the belief that in the assessing team, it was doctors who were more risk averse, and that the AMHPs have more contextual information preferring to follow less restrictive options. There was the belief expressed that doctors sometimes minimise social perspectives and were more focused on non-compliance with medication as the cause of relapse, rather than social factors. This also expressed itself in relation to outcome decisions, which AMHPs felt doctors sometimes tried to pre-empt before the assessment had taken place or tried to push the AMHP into a decision they did not believe was the least restrictive. These perceptions by the AMHP are consistent with authors (Hall, 2017; Morriss, 2015) in the literature who found that AMHPs believed their approach on this subject was distinctive from others.

“On another situation this weekend, I had a very long discussion with a doctor about whether a young woman with learning disability should be admitted to hospital, I felt that he immediately, as soon as he saw her, made the decision that she needed to be detained

without considering any other option whatsoever and for me it just simply wasn't clear cut, so I made sure that we gathered the information we needed from a range of sources which included a residential home." Q1

"I think doctors can be very risk averse and it can be depending time of day, I mean when I have been to places where applications have actually been made out, which is fair enough.... the person been interviewed by myself and another doctor and its completely kind of different it's not just about the degree and stuff" D1

The difference of opinion was not always based on the doctors wanting to detain and the AMHP believing otherwise. There were occasions when it could be described as the AMHP being risk averse as they were the ones who believed the person should be detained. Sometimes this difference is between the doctors, sometimes it is one doctor concurring with the AMHP and the second doctor taking a different view. The AMHPs describe complex negotiations taking place.

"on a couple of times she'd had thoughts of jumping in front of the train and she had actually been sat on the train and got up to jump off the train however, another passenger had come along so she sat back down to be polite..... So, we conducted a Mental Health Act assessment, the consultant who knows her well thought she needed a detention, I thought she needed a detention, the other medic didn't think she needed detaining and he thought Home Based Treatment." H1

The AMHPs expressed an appreciation of these differing perspectives as a way of ensuring a more consistent approach to decision-making and acknowledged that other professions had influence over different parts of the process, depending on the decision to be made. A finding of the study was the implicit understanding among AMHPs that decisions that impact a person's liberty, choices or may result in treatment against their wishes ultimately is a collective decision, as all the participants must agree for a detention application to be made. The AMHP makes the decision to call for an assessment and must be agreeable to making an application. However, medical professionals have greater influence over the decision as to whether to make a medical recommendation or whether to renew someone's detention. This is consistent with the findings of Peay (2003). There was also evidence that

the AMHP would consciously seek to involve a doctor who knew the person in order to bring this additional perspective to the situation.

“Well I’m still speaking to his team I would be wanting more specifically his doctor, his psychiatrist from that team to be undertaking that Mental Health Act assessment with me because he knows him and that kind of good practice and all that kind of thing. I would like if him and even his GP as well which would be even better because then you have got 2 doctors there that know this guy. I don’t know him so I can go face value, and that would help in the decision-making”. M1

The AMHPs acknowledged that it was not just about different perspectives but also about different roles. The medical professionals may consider that making a medical recommendation for detention is not appropriate, therefore an application for admission cannot not be made by the AMHP. Similarly, an AMHP makes an independent decision as to whether or not to make an application for admission, after considering all the circumstances of the case and, even if two medical recommendations are made, there is no obligation on the AMHP to actually detain the person. Although medical perspectives were not a part of this study, it was clear from the interviews that the AMHP would expect to discuss differences in assessment recommendations and that sometimes no agreement is reached, as to the level of risk presented.

“I had an assessment it were almost, it was cut and dried ..... the doctor that had done the first medical recommendation on the ward, wanted this gentleman to be detained on a 3 so they could look at a CTO, this person, it were bizarre he were out on leave and we had to wait for him to come back he’d been on overnight leave and we had to wait for him to come back to undertake a Mental Health Act assessment for a section 3 and it were I said this is not right I think the argument was that he’s time and time again this person slipped through the net and we’ve got a real opportunity to get him on a section 3 and on a CTO but I just thought how bizarre is that he’s doing everything that’s asked of him he’s got really good insight into his mental problems he’s taking his medication so why would you want to do a section 3 so I ended in conflict with, and the second doctor were a little bit like ooh you know that person knows him best and I feel bad that were not going to do an application and he was fine after that he stayed in hospital he stayed as an informal patient and he

worked with services so sometimes this is what needs to happen and if you don't do it they are not very happy." P1

The belief was expressed that sometimes conflict was created when other agencies either did not understand the process of an MHAA or their agency's role in this. AMHPs describe the tensions arising from trying to liaise and coordinate with the police, ambulance, HBT or the people responsible for identifying inpatient psychiatric beds. This again reflects issues identified in the literature (Hall, 2017; Morriss, 2015).

"Yes – it's mainly the assistance bit, you know when it's kind of said about a community assessment because I think that if you need assistance quickly it's not happening, I think the police are better than ambulance service, way better than the ambulance service..... I've been sat in a house with fortunately she was little and frail for 4 hours and that was like from 8pm" M1

The AMHPs described the impact that these conflicts or misunderstandings can have on their ability to undertake what they see as their core task which is to ensure the process considers the needs of the person and that the correct legal procedures are followed. There were also additional pressures such as negotiating with health managers about the availability of inpatient beds, multiple conversations with agencies such as the police and ambulance service regarding the person's conveyance to hospital and sometimes legal disagreements with another organisation about the correct pathway to follow. These personal pressures are identified in the literature (Dwyer, 2012; Gregor, 2010) as real time pressures on the AMHP. The AMHPs acknowledge that these additional responsibilities do have an impact on them as a decision-maker partly due to the additional stress that this creates.

"sometimes we have very heated discussions with police, bring people to the 136 suite who are not appropriate for the 136 suite, or we ask for support and the police don't think it's appropriate to support and again it's about stating the case and being really clear, often with the police" G1

“The bed manager can’t find you a bed and you're waiting around for ages, you’ve potentially got a really difficult situation and that’s no good, so you could be on to the Trust to try and really push them to make things move, all sorts of potential conflicts. It can be a really stressful situation because you’ve got a 100 things going off at the same with all sorts of people in the mix who have all got their own roles and targets you know, and you’ve got to coordinate everything and sometimes their aims go against what your trying to achieve so it’s trying to get them all to work alongside you so it can be quite stressful” A1

The AMHPs also described feeling personally conflicted; this took several forms, including conflict with themselves when they are out their comfort zone and assessing people from service user groups they are not familiar with, or trying to convince others of a course of action when they are not sure themselves and reflecting afterwards about whether the decision to detain or not was the right one. The AMHPs also talk about situations with other practitioners where their decisions are put under scrutiny and they feel under pressure to accept a dominant organisational view. This is expressed as feeling conflicted because the options available to them do not sit easily with their value base, either because the person was detained due to less restrictive alternatives not being available, or they do not believe in the efficacy of psychiatric admission. Some AMHPs express feeling unhappy about the dominance of the medical model in psychiatric hospitals, which included the perception that sometimes they were condemning people to be a lifetime psychiatric patient.

“There is a suggestion that it’s the medication that keeps people unwell rather than there being an alternative system, so my own beliefs are more in order with the medical model than I would like them to be sometimes. “B1

“but you feel like you’ve just been backed into a corner sometimes but that’s negotiation and rarely but there has been on the odd occasion you may have a disagreement with the doctors when they want to admit and I’m not happy to make that application but that has been few and far between in my experience to be fair” L1

“Yes, I am trying to think, I think one of the difficult most difficult areas is around the issue of personality disorder and what you can or can’t do for somebody with personality disorder. I am just trying to think back about assessments I have done, and this maybe says more about me but I seem to be having less conflict with doctors than perhaps I used to do and I don’t know that’s because I don’t think I have become more immersed in a medical culture I hope I haven’t” N1

The AMHPs did acknowledge the pressure that they sometimes feel from the expectations of family members. Although this was not cited as a significant factor in the decision-making process, there was an acknowledgement that not detaining could have negative consequences and they may be held accountable for that. This reflects the findings of various writers (Pilgrim, 2014; Ramon, 2005; Szmukler 2018; Warner et al., 2017) in relation to decision-making in mental health. The AMHPs describe that at times they will make a decision to detain because the family can no longer cope with the stress of supporting someone and reluctantly accept there are no viable alternative supports available that provide a less restrictive alternative. A significant issue raised in these interviews with regard to challenges of working with families was primarily about responding to concerns but also about families wanting to negate their own legal responsibilities particularly in relation to the powers of the nearest relative. However, there was empathy shown as to why this may be the case.

“They might already be detained, it might be a nearest relative request, sometimes we get requests from relatives asking for them to be detained and listen to their perception of what they think, there’s probably a lot more” H1

“Sometimes the conversation can go along the lines of if you don’t want to have the responsibility of the nearest relative you can request another family member, which I have done in the past, and they feel more comfortable with that because there is a lot of guilt attached to having somebody in your family detained. Especially when they know their rights and they know their family member has had some say in it, it can be quite straining on their relationship”. G1

The perception that there may be negative consequences for the practitioner, should there be a negative outcome, was not a significant theme arising from the interviews. There was no evidence of decision-making based on an aversion to risk taking in the context of the options available to them, although the AMHP believed they could experience criticism should harm come to the person because of a reluctance to use compulsory powers of detention. The primary focus of decision-making remained the potential of harm to the person and those around him including family and friends rather than vicarious harm to the AMHP.

There were various references to differing professional perspectives and how different decisions could be made depending on the circumstances that the AMHP is presented with. AMHPs were certainly cognisant of these differences but did not necessarily identify these as problematic. The evidence suggests that the decision whether to detain someone under the MHA was explicitly considered within a legal framework even when the decision could appear pragmatic. One of the emerging themes in the literature was the impact of other legislation particularly MCA, the capacity element of this, the person's participation in the process and how their views are considered are discussed in the next section.

#### **4.6 Capacity, Insight and Understanding**

The *empowerment and involvement* principle of the MHA encourages the participation of the person being assessed, which implies there is the necessity to involve them in the decision process. This inevitably presents the question of the degree to which the person can be involved in the process of assessment and make their own decision about risk concerns. The *empowerment principle* also interfaces with the requirement to consider the person's capacity (Allen, 2010). The tools the AMHP uses to incorporate the person's views and how they process these views are important in the decision-making process. There was evidence that the AMHPs were attempting to involve the person in the assessment discussion in several ways. Firstly, to assess the possible presence of symptoms and ascertain if there was a mental disorder of a nature or degree that required intervention. The term insight to describe the person's presentation or perception of the situation was commonly used in this process and also as a way to ascertain if there was need or risk arising from any presenting mental illness, i.e. did the person acknowledge this and were they willing to engage with services and accept

the problem as perceived by those undertaking this assessment. The complexity of this process has been identified by various writers (MacDonald, 2010; Rapaport et al., 2009) although they have not specifically dealt with the issue of insight and capacity.

Regarding the possibility of a less restrictive option, there are several issues that appear to be weighed, such as the person's own understanding or acceptance of these issues, which included:

1. The person's current presentation and risk to themselves or others.
2. The possibility of negative outcomes should nothing be done.
3. The person's understanding of their "illness" and willingness to engage with treatment/services (Insight being an element of this).
4. The person's history of risk behaviour and their history of engagement/non-engagement with services.
5. The person's capacity to consent to their treatment, this is particularly evident in the discussion about whether the person can consent to informal rather than compulsory admission.

The person's participation around the question of risk focused on the question of whether he had insight and concurred with the professional's view that he was experiencing symptoms of a mental illness. The concept of insight was used as a method of assessing risk; did the person have a sufficient understanding of risk to themselves or others arising from their mental health problems and were they willing to work with the AMHP collaboratively on managing these perceived risks. The possible contradictions of this were also alluded to by the AMHPs not as a critique of insight in relation to concepts of capacity but more as a critique of medical approaches to mental illness.

'OK, what we, it's a health term, and by insight what they mean, or what I understand it to mean is that the person doesn't accept that they are ill, so the counter argument is maybe they are not ill, or maybe it's just a disagreement but it's a thing you see a lot in pink forms, person is ill, has no insight, won't accept help, needs to be in hospital "O1

This critique assumes that the person being assessed also understands the concepts that the assessing team are working to and anticipating the possibility of them being detained and therefore disguising their compliance by appearing to be concordant with the assessing team.

“he appears to be lacking insight or some partial insight he’s telling the professionals what they want to hear but reality is that he is not complying, not really engaging it’s likely that he’s using some substances, and we don’t know what social stresses are going off you know”

L1

There appeared to be occasions when the concept of insight and the concept of capacity were used interchangeably. This raises the question of whether capacity to consent is being assessed by the AMHP as a specific functional test. Or are they conflating issues of capacity and best interest dependant on the level of perceived risk and using insight as an alternative concept. The evidence was that the concepts of capacity and insight were on occasions used interchangeably, although the concept of insight was used primarily as a risk assessment measure, while capacity was described as a measure of understanding regarding decisions and the legality of a specific decision to be made. Here the AMHPs are using the term insight interchangeably with the concept of capacity.

“In terms of that he lacks insight doesn’t he, that’s the bit for me, you know he might, if I’m talking to him or the Doctors are talking to him you know we think you should be in hospital for a little while, he’s going to turn around and say either yeah alright and walk in one door and out the back door, or no off you get out of my house kind of thing, and really object to, so that would be the kind of thing that I would be considering at that time.” M1

‘I think that’s based on that if he believes I think he believes that all these conspiracies and his wife’s involved with housing and all these, I think firstly he lacks insight and I don’t think he is able to make decisions that would I think he’s unable to make wise decisions that could guarantee his safety because he just seems as though the plots getting thicker and thicker’

P1

The assessment of capacity is decision specific and not a generalised concept like insight. In other words, the AMHP is not assessing global understanding but capacity in relation to a specific question; in this case being able to consent to informal admission or HBT using MCA principles within the context of another legal process. A significant element of this engagement was to determine if the person had the capacity to make an informed decision about the proposed care or treatment that was being suggested. Here the assessment of capacity was considered explicitly as separate from the assessment of insight. This was clearly a conceptual tool being used as a key determinant in eliminating less restrictive alternatives, such as HBT or informal admission.

“I don’t think an informal admission because we would have had that point have ruled out that he has capacity to agree to an informal admission. So, I think we would have to rule that out straight away ..... I don’t think he would understand I don’t think he’d understand he’d be going into hospital and he’d be and free to leave so I think we wouldn’t consider, well we would have to consider lacking capacity I don’t think an informal admission would be an option” P1

There was evidence that the AMHPs were applying the principles of the MCA to consider options relating to hospital admission. They were cognisant of the requirements for informal admissions and stated the elements of admission they would need the person to demonstrate understanding of.

‘He would have to have capacity to fully understand what he was committing to in regards to an inpatient that you know that he would be expected to follow a certain, you know engage with therapeutic interventions and work with the assessment teams with the nursing staff, remain on the ward if they requested him to, possibly if he is a smoker stick within the smoking boundaries and not smoke within the hospital grounds and be using smoking breaks or however they fit it, he would need to understand all the situations of going into hospital as a voluntary patient.’ I1

Although the language of capacity and insight was at times interchangeable, AMHPs were aware of the necessity of using the principles of the MCA when agreeing to an informal admission. There was also evidence of the impact of the Cheshire West (2014) ruling under the MCA: that a person should

not be subject to care arrangements that amount to a deprivation of liberty if they are unable to consent, unless they are protected by a procedure prescribed by law.

“Since the advent of the Mental Capacity Act and the Cheshire West case if someone was going to consent to informal admission they must be assessed as having capacity to do so. So, the chap would have to understand that by being in hospital there would be rules and regulations that he could follow. That he wouldn’t be allowed to leave just because he wanted to and that they could prevent him using their powers under Section 5. That he would be searched and there are a whole host of things that you would expect him to agree to. There would also have to be some acceptance that he needed to be in hospital and from what you’ve said that would appear to be absent, or it has been in the past. You wouldn’t discount the informal option straight away, but it would appear from the information that you have given me that that might not be a flyer.” B1

In some ways, the fact that the use of compulsory measures under the MHA is still possible, even if the person has capacity, negates the discussion about the use of MCA, but the COP/MHA clearly states that the assessment of capacity should follow the principles of MCA. In other words, the practitioner decides that a hospital admission is advisable or desirable. They ask the person to consider this based on the information they give them. If the person has the capacity to consent, and gives consent, an informal admission is legal. If the person lacks the capacity to consent, an informal admission is not legal. If the person has capacity to consent to admission, the MHA and its compulsory powers are considered in the following way:

14.14 When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent is consenting to admission.

14.15 This should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder.

14.16 Compulsory admission should, in particular, be considered where a patient’s current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or

after they are admitted, with a resulting risk to their health or safety or to the safety of other people.

(COP, 2015)

The MHA does not require the person to lack capacity before action is taken, therefore the assessment of capacity takes on a unique role in the context of an assessment. The person is being assessed under mental health legislation but their understanding of this is assessed using mental capacity legislation guidance. There was evidence that the AMHPs did understand this and would consider detention based on risk concerns regardless of the assessment of capacity. The concern that regardless of what the person says, they may show their objection by absconding was also identified as something that overrides the assessment of capacity.

“That he point-blank refuses to go to be admitted, or again its very subjective a judgment call, the balance of probability and likelihood that once he’s there he’s likely to abscond or you know, or if you felt that he lacked capacity to consent to an admission, if he lacked capacity to consent to an admission then he’s being detained.” C1

“He would have to agree to it, he would have to have the capacity to agree to it, as well I think but if he was flat out, there’s no way and I felt that there was risks there for him and for other people I think you are then stuck in this idea that you’ve got to possibly detain him really in my view.” G1

There did not appear to be any occasion when the person’s capacity to refuse being assessed is considered. All the AHMPs who participated in the study would continue to pursue the MHAA, either by persuading the person to allow them access or seeking authorisation of a warrant under Section 135. Some interviewees did state that they would phone the person that they were coming to his house to undertake an assessment, forewarning him and therefore presenting him with the option of not being at home. However, none of the participants stated that they would stop the process if he did not give his expressed permission to assess him. The question of level of involvement by the service user in the process of having decision-making capacity assessed is considered in the literature by McDaid and Delaney (2011) but more from the experience of the person being assessed.

In terms of the decision-making process, there does not appear to be anywhere prior to or during the assessment itself where the assessment of capacity led to the consideration being given to the use of MCA, rather than MHA as a treatment pathway, either with regard to admission or to treating the person at home using the best interest principle of MCA. This may have been different if the case study had included someone with dementia or a learning disability, as various writers identify (Manthorpe et al., 2008; Rapaport et al., 2009) there is still a separation in the minds of practitioners as to who the MCA and the MHA are applicable to.

The findings suggest that the participation of the person in the assessment is partly to assess the person's view in relation to perceived risks. It incorporates an element of assessing compliance or concordance with proposed treatment and there is also consideration given to the person's capacity to understand treatment options including informal admission into hospital. Ultimately, the AMHPs show awareness that regardless of the person's capacity or lack of objection to admission, the AMHP has the option of using compulsory powers if they consider the risks are sufficient. In the next section the consideration of wider social factors is explored.

#### **4.7 Social Factors**

The responsibility of the AMHP to consider social factors was an issue identified in the literature (Campbell, 2010; Hatfield, 2008). When deliberating on the need to undertake an assessment, or when considering the outcome of an assessment, AMHPs looked at the person's social circumstances in a number of ways. Firstly, as a way of giving context to the person's behaviour which was another application of the counter-intuitive approach, by trying to give context to the person's presentation in terms other than as a medical mental illness. Social factors were also considered as a way of identifying factors contributing to the person's mental distress and also how these factors may be negatively impacting the person's mental health.

"I think it would be the acknowledgement that we are all different, I would be doing the interview or I would be reflecting back to him and then acknowledging what he's feeling and

what his concerns are, I would be open and transparent as I could about our concerns, I would be trying to engage with him, what's bothering him other than like the social stresses that he's got and trying to help him see that he has got a build-up and the bucket is overflowing and there is support there and yes he may feel different but different is not always a bad thing. It's just about helping him and reducing those stresses and finding a way to help him with that and hoping that he will engage with" L1

Some of the factors that were considered related to the person's inter-personal history or current circumstances, such as family or neighbourhood relationships. Consideration was given to the person's social circumstances and how this possibly explained his current presentation; this included historical factors such as his childhood, separation from his wife and stressors with his neighbours.

"about the difficult relationship with his dad, the loss of his dad, before he's had the chance to sort of figure it out between them, so there is that bereavement and then there's loss of that chance to sort it out on top of it so he's left with all the bad things rather than any of the good things and he can't resolve it so you can sort of see the broader non medicalised issues that might lead into where he is now." O1

"So whilst I would listen to what she's saying obviously and especially the bit about his dad being a drinker his dad often being physically and verbally quite violent and that would impact on any person's mental health as they got older the kind of experience that in childhood, that would be the bit, I would listen to it you know and its certainly worth considering especially in terms of psychological therapies at a later date," M1

Socio-economic factors were also considered, but more in terms of what support networks the person had and how social factors such as gender, race, and age might have impacted on the person's mental health.

"I hope there would be some level of awareness of difference there, but actually there probably is but perceived as different and perhaps he doesn't fit in and perhaps there is

animosity that's not entirely driven by the way he behaves or perhaps he behaves that way because everybody hates him so why should he be polite around people that are racist." O1

The question of the person's ethnicity was intentionally made ambiguous, although hints in the vignette suggested that he was possibly not white British. This was commented on and, when discussed, it was not identified as a consideration regarding the necessity of detention. The discussion primarily focused on the negative impact racism has on the individual.

"I suppose I haven't asked anything about ethnic origin that raises a big question about his ethnic origin as well, all I was thinking about that information is there is a plausibility in what he is saying potentially" N1

"I'd explore why he thinks his neighbours are racist, why he's got all these feeling about other people, what makes him think that" M1.

"OK – that's a lot clearer in terms of a mental disorder, now that still doesn't mean that I need to section him but, the police may not like him you know the police are racist still, not as much as it were but still. "O1

"There is always a possibility that the neighbours don't like the idea of the reggae music and smoking the cannabis and there could be some racism attached to it." I1

When considering social factors, the necessity of assessment or detention also took into consideration the impact the person's mental health had on their functioning, including questions relating to, evidence of self-neglect or evidence of protective factors that made the necessity of intervention less likely.

"There's reason into why he's being how he is. Is he neglecting himself, when was the last time he had eaten, what's his sleep pattern, you know does he look like he goes to bed or he might be in squalor that could be causing an infection"? R1

“I want to know what his functioning is like, what’s his flat like, you know has he got food, has he got food in the fridge, has he been out, is he kempt you know you are looking at all the other stuff that he doesn’t say as well. What’s his level of functioning like what he does day to day” H1

The consideration of social factors in relation to symptoms and behaviours was not to necessarily negate the belief that mental illness was present but to give context and understanding to the person’s presentation. This could include identifying historical factors or current stressors that were thought to be significant life events that impacted upon the person’s mental health.

“So if someone says to me that I’m a single man in a 3 bed roomed house and the council want me to move out so a family can move in then I think that’s perfectly logical and probably true in terms of that’s the way that council departments can operate. But if they say to me in order to do that they have got cameras in my house and they are monitoring my every move I make and I can’t go out without someone spying on me and following me then I would think then what could be a rational belief becomes paranoid in flavour and it’s the paranoid nature of it which would trip it into the Mental Health Act and not to be a belief. I mean often in my experience when people who are paranoid for example there’s usually something at the core of it which was a true event, or something did occur. It’s the fact of how it’s been interpreted that makes it different from how you or I would perceive it to how the way they perceive it.” B1

Breakdowns in social relationships were also viewed as a perceived risk which could have a negative impact on the person, which could develop if there was no improvement in his current presentation. This included breakdown in significant family relationships, for instance, with his children. Other negative impacts identified were a deterioration in the relationship with neighbours and possible negative outcomes such as loss of his tenancy. The rebuilding of social relationships was consistently expressed as a desired outcome of hospital admission if that became the outcome of the assessment. This paradoxical view of involvement in mental health services which considers the therapeutic as well as iatrogenic effects was a theme in the literature. (Campbell & Davidson, 2017; Pilgrim, 2014; Ramon, 2005; Szukler, 2018; Warner, J et al., 2017). This was another example of

the consideration of factors within the time dimensions, here relating to future possible outcomes, as concern expressed about potential future negative effects on wellbeing and social functioning.

“Well I suppose a timeout period of getting his mood stabilised if that’s what needs to occur you know. Re-establishing relationship with other people, people who mattered to him, if they do matter to him, making assumptions, he might not have anyone that really matters to him, and obviously he’s building his support network backup – again I’m judging as he might well be quite happy being solitary but there’s all them sort of issues.” E1

“Generally speaking I’m not a fan of people being medicated forcibly, there is enough evidence to suggest that people being given anti psychotics is damaging to their health and also reduces their life span and does all sorts of nasty terrible things and the side effects of the medication is horrendous. There is a suggestion that it’s the medication that keeps people unwell rather than there being an alternative system so my own beliefs are more in order with the medical model than I would like them to be sometimes.” B1

Social factors were viewed primarily in terms of identifying countervailing tendencies to understanding and contextualising the situation. The findings suggest that the AMHPs identified social factors that could be considered as risk indicators. However, these were not identified as pre-determinants of detention\_or\_as actuarial indicators of risk. The focus of the interviewees was predominantly on the person’s mental health history, current presentation and immediate social circumstances regarding how this impacted on the person’s mental health and how his behaviour or presentation impacted on others. The consideration of all social factors was multi-dimensional or multi-layered and were used as part of the critical analysis of other legal and risk frameworks of understanding.

## 4.8 Conclusions

The analysis of the interviews has provided the landscape within which AMHPs make their decisions and there are some indicators of the deeper belief systems about their role. The interview findings support the belief that AMHPs do not start with a blank slate when considering the request for a MHAA. In the first instance they are conscious that they are working within a legal framework and that they have a specific role to undertake.

The law frames the work that they do but there is a considerable degree of flexibility about how its elements are interpreted. The consideration of criteria for detention, principles of the MHA and case law are evident although not always stated explicitly. The consideration of health, safety and the protection of others is considered primarily using a risk agenda and the AMHP populates these risk areas using knowledge of the person and information about the current situation using their own frameworks of understanding based on what appears to be practice wisdom and tacit knowledge.

The factors they consider have consistent themes across the interviewees and also have a consistent additional time dimension. The AMHP receives a referral based on current concerns, checks these against historical information to make a decision about undertaking an assessment. These considerations are then synthesised to make an approximation of future outcomes based on the frameworks of understanding developing into hypotheses that are considered, tested and reformulated.

An important element of this is the interplay between the different participants in the process particularly the AMHP and the doctors. There was an awareness shown of the ways in which the roles differ but also how conflicts arise around role and ideology. The consideration of social factors underpins the role of the AMHP and there were hints of this in the interviews but one of the findings is that if you ask about the process of an assessment this is primarily what the AMHP will talk about. To consider the deeper beliefs about the factors that underpin this process a focus group of AMHPs was undertaken and the findings are presented next.

## 5. FOCUS GROUP FINDINGS

The focus group was made up of seven AMHPs from the same local authority as the AMHPs who participated in the interviews. The AMHPs were approached on the basis that they had not been involved in the previous interviews but as with the interviews they represented AMHPs working across a variety of service areas and with a range of experience. As mentioned in the conclusion to the last chapter, the purpose of the focus group was to explore the deeper ideological concerns of the AMHPs, how they rationalise their role and how they develop this meaning as a group of professionals. The case study boundary of AMHPs from a single local authority was maintained.

To avoid the discussion being routed down a consideration of the process of assessment it was decided to pose a single question that would challenge the AMHPs to consider the deeper meaning of their role. The critical realist perspective that I adopted for this research is based on the belief that the AMHPs will have a collective foundation of knowledge and beliefs that their practice is built on. The critical realist also believes that this can be investigated but the right methods of investigation including the question/questions need to be posed. In this focus group they were asked one planned question, “Do we need a Mental Health Act?” additional questions were only asked where clarification was needed or where the discussion appeared to be stalling or losing direction. Although the question is short and apparently simple, it was chosen, through a process of critical reflection with my supervisors, because I felt it challenged the AMHPs to consider a range of possible questions. This included the necessity of legislation to protect the individual in terms of risks to themselves or in relation to their human rights. I believed it would invite the AMHPs to consider the nature of mental illness itself and associated issues such risk concerns. Also, by asking, do we need a Mental Health Act? It leaves open the question about do we need it as professionals? Does the individual need it? Or is it a more general societal concern about mental illness and risk?

By using a group of AMHPs from a single authority and asking them to consider the same question kept the focus group boundaried but allowed the AMHPs to develop their own themes and understandings as part of a group process. The construction of meaning and understanding by groups, in this case AMHPs, was evident and supported the view of various writers on this process (Brannen & Pattman, 2005; King, 2010; Morriss, 2015). This enabled me to observe and analyse how as a group of AMHPs they collectively posed questions, answered them and deconstructed their own perceptions

as a group. The data was analysed thematically and is presented in the findings, in a contemporaneous form to illustrate how the AMHPs developed their themes and developed a collective meaning or understanding of their beliefs and actions.

### **5.1. Legal Safeguard**

The initial consensus of the participants was that it was necessary to have mental health legislation as a legal safeguard. This was seen as a necessary protection against arbitrary detention by the state. The concern raised was that, without this safeguard, the medical profession and relatives would have too much power and people could be deprived of their liberty without recourse to a legal process, including the right to appeal. This indicates that the AMHPs adopted a rights-based approach in their critical reflection; this was something that MacDonald (2010) identified as a feature of social work decision-making, particularly when the social worker was also an AMHP. AMHPs stated their belief that prior to the existence of mental health legislation there were not any safeguards for those deemed to be mentally unwell.

There was also the perception that, without legislation, detention in hospital would be inconsistent and that mental health legislation provided boundaries and guidance for professionals and safeguards for those being detained. The belief was also expressed that legislation did give a guarantee that a minimal service was available when a person was experiencing mental distress and needed help.

The immediate response to being asked the question “Do we need a Mental Health Act?” was that the participants considered what it would be like without such legislation.

“W1 What would we do without a Mental Health Act is the corollary to that isn’t it?”

S1 how it would work without a Mental Health Act then, what would... I’ve tried to think of how we would work if we have no legislation whatsoever, around, not just detention, around just like only working with people’s mental health. “

The participants described the situation that they believed prevailed prior to the existence of legal safeguards. A situation in which people's mental ill health went untreated or where the state was able to impose arbitrary detention on people without accountability. This reflected some of the historic issues relating to the ill treatment of people with a mental illness as suggested by (Cohen, 2016; Ferguson, 2017; Scull, 2015), this will be discussed in more detail in the discussion chapter.

“U1 Increased risks of deterioration in people's health and risks to others that is what we are protecting people against isn't it, with the Mental Health Act.

Y1 People in power imposing their views of what should happen in those kinds of situations

S1 Just a massive inconsistent approach (V1- yeah) to how we deal with anybody with any kind of mental health issue.

T1 Asylums you know where people were just caged sometimes for the rest of their lives without any kind of, you know, opportunity to recover or to live or learn to live with their illness.”

The discussion at this stage focused very much on mental health law as a positive legal safeguard that protects against arbitrary detention and builds in safeguards that act as a counterbalance to the medical profession or the views of family members. This was based on the belief that legislation had been a positive step forward set against what they believed had prevailed prior to legislation. There was no indication at this stage that mental health legislation had a role of social control as argued by some writers (Pilgrim, 2014; Ramon, 2005; Warner et al., 2017), who believe that the legislation reinforces the power relations in society.

“ W1 A legal framework for detaining people and for independence, just thinking about you saying about going back to the old ways, you know, to people being detained on the say so, solely of a relative. (T1 –yes) Plus a medical professional for an indefinite period. (T1- yes)

S1 There is that safeguarding in the Mental Health Act, so even if you are detained then it's about that continued detention so having tribunals and (V1- by their rights) yeah, about those safeguards and those being regularly reviewed."

The existence of legislation was seen as something that boundaried the AMHPs decision-making as a legal safeguard and was also a partial guarantee that the service user could receive some kind of service when they were in most need. The caveat to this was the AMHPs belief that the system they were working within and the end result of admission to a psychiatric unit were not the ideal outcomes for people experiencing mental distress. In this part of the discussion the AMHPs started to move towards a more critical view of the legislation which acknowledges that the decisions being made are about keeping people safe from harm without necessarily being about therapeutic benefit.

"S1 And the fact is we do have a Mental Health Act, and whether we necessarily agree with it or not, or parts of it you know or we fundamentally disagree with it; those are, we are bound by that legal status, that legal framework at moment aren't we.

W1 Without a Mental Health Act would people have a right to be contained when they want to be contained? You know the old notion of asylum as refuge. Sometimes people need (S1-an escape) an escape, if you're rich you can go off to, I don't know the Caribbean island, or to a retreat or a yoga spa. But if you're poor sometimes people just want to feel that they are safe don't they.... "

These responses would suggest that, in the first instance, AMHPs see their role and decision-making as guided by legislation which is designed to protect people's human rights. Either Article 5 human rights protecting them from arbitrary detention or Article 8 rights to privacy and freedom from interference in family life. They also suggest that other rights, such as Article 2 right to life or Article 3 protection from degrading treatment, are protected by legislation that puts a positive duty on public authorities to intervene in the person's best interest, if they are at risk of suicide or other harm. There was no counter at this stage in the discussion which considered the possible benefits of not having specific legislation relating to mental disorder or the notion that having legislation that targets one group in society is discriminatory. The AMHPs valued their role, whilst at the same time

accepting it as compromised or dirty work which echoes writers (Dwyer, 2012; Gregor, 2010; Morriss, 2015; Vicary et al, 2019) who identified the paradoxical feelings that AMHPs often feel about assessing and detaining people.

## 5.2 Views of Mental Illness

The necessity of a MHA was questioned on the basis that there may be a need to go back to first principles and question the existence of mental illness as an illness in the medical sense and how mental distress is interpreted and defined. This discussion was initiated by one participant, who raised the point that the necessity of legislation is premised on the belief that there is such a thing as mental illness. This concept, that the existence of mental illness may be socially constructed, was explored further in relation to dominant ideology and how this construction could be based on dominant beliefs about issues such as religion and culture. This discussion reflected the theoretical debates identified in the literature and some of the criticisms of psychiatric positivism proposed by the critical realism of Pilgrim (2014), these links are considered in more detail in the discussion chapter 7.

“W1 It kind of poses the question of what do we think, what do we think madness and mental illness is as well doesn't it. That's the one that is kind of the bottom of everything. “

Questions about the perception of what mental illness is included the misunderstanding or misinterpretation of the behaviour of others. This was described as arising for a number of reasons including lack of cultural awareness, when mental health practitioners consider people's behaviour as a sign of mental illness when the behaviour arises from deeply held religious beliefs or customs. The AMHPs also intimated the belief that behaviour that arises from life events is often medicalised and considered as mental illness rather than being contextualised.

“S1 And that's very subjective, that is very subjective you know and cultural. (Participants agree) If you look at some of the cultures what we consider is somebody being totally

crackers is someone who has got a special gift and is someone to be sort of revered and praised...

X1, I think another part of experiences is, that comes into mental health sometimes is religion. Which I find quite interesting cos I've sat in meetings where people are really worried about somebody and I think well my grandma was a bit like that, all this praying and chanting or whatever. And people worry about that and see it as an illness sometimes, which is interesting.

W1 And there is also the question of what drives people mad, in quotation marks, you know what is it about our society that erm pushes people to the edge either in terms of how they feel, how they behave or what their beliefs become. "

The AMHPs are considering what the consequences are of not contextualising behaviour particularly the possible negative outcomes for the person being considered for detention. This included the acknowledgement that people's belief systems, even when they appear bizarre to others, may constitute an important coping mechanism or method of healing for the person and by suppressing these cultural/religious beliefs and customs we make the situation worse for the individual.

"X1 I've actually got to know someone in particular I'm thinking of and she is genuinely really religious you know; it means a lot to her. And to take that away from her, they can't just suppress it with drugs you know they're giving her all this medication and then yeah, she isn't religious anymore, but she is so miserable. Why would you want her to live like that? (Participants agree)

W1, I worked with a woman from erm, she was Catholic from (African Country) and her religious belief was actually a really important part of healing from basically some delusional beliefs you know, but it was very important to acknowledge that her religious beliefs were not part of her delusional ideations and to work with that. "

The belief was also expressed that some of the presenting behaviours may be unintelligible to others even though they have a material base in culture or real existing circumstances and experience. As identified in the interviews the AMHPs considered that it is important to seek the views of others to

contextualise people's behaviour and even when there is evidence that the presenting behaviour can be considered as a symptom of a mental illness there is the further consideration of associated risks

“ U1 And that's why we have the Nearest Relative safeguard because we can ask the Nearest Relative if that's what they're normally like and that's like part of their usual, because it would seem bizarre if you didn't (*The participant is commenting here on the legal safeguard that the role of Nearest Relative brings to the process*)

“ X1 and on the other hand I was quite shocked to hear that one of our service users had gone all the way to (another city) to see two priests that were doing an exorcism on him because they felt this would cure him. Two catholic priests. I didn't know that still went on. There're two sides.

S1 Who are we to say that that's not something, that would have benefitted that person, I think then it comes down to risks doesn't it. We can all have our own beliefs. Well you can't be eccentric anymore can you we all have to fit into this normal society (participants agree)..... when does that tip over into being unsafe either for yourself or for somebody else? “

There is an acknowledgement here on the part of the AMHPs that their own lack of cultural knowledge could lead to misperceptions about what is mental illness. This, they believed, was compounded by a lack of service provision that could compensate for these issues. The examples given were the lack of a robust interpreting service which meant that the essence of what they were trying to do in assessment i.e. consider all the factors and bring context, were impeded. It also included the lack of services that were able to support particular BME communities with the issues that they faced in relation to their mental health

The belief was expressed that this lack of consideration could partly be explained by the dominance of medical models of understanding distress, which is reflected in the legislation and the beliefs of medical practitioners and Mental Health Tribunal members. This reflected the notions of western cultural dominance promoted by the pharmaceutical industry and professional psychiatry described in the literature. The medical model (Kutchins & Kirk, 2003; Watters, 2010; Whittaker, 2002) was also seen as something accepted across society and that medical hegemony was such that the general

population also held a medicalised approach to resolving problems. This is institutionalised through training of those who consider these questions including doctors and mental health tribunal members.

“ W1 The legal framework though is very medicalised isn’t it (S1-yeah) and it’s very driven by that, you just have to work your way down it and it’s all medical.

T1 But the law is very medical isn’t it, the way that it’s written and the way that the judicial processes favour the medical model to others, listening to the doctor more than they listen to anybody else you know

Y1 We’re leaving out the information that tribunal panels are given for training it’s all medical driven anyway. It’s very laid out in that way.”

There was acknowledgement that sometimes the AMHPs lack cultural awareness or their personal values impacted on the assessment. The lack of cognisance in relation to cultural factors was partly attributed to the fact that some of the AMHPs lived and worked in communities that were not diverse in relation to BME communities. Therefore, they came to the assessment with limited knowledge of other cultures and possibly stereotyped views that could be unhelpful. Some went as far as expressing the belief that this lack of cultural awareness could be described as institutional racism. The discussion also reflected the belief (Ferguson, 2017; Hatfield, 2008; Watters, 2010) that a combination of poverty and disadvantage increased the possibility of people from BME backgrounds experiencing mental distress, which was compounded by a lack of understanding of how different groups experienced distress. This created particular difficulties with the context of a formal assessment to consider detention as the AMHP does not have the necessary tools to contextualise distress or offer less restrictive alternatives that are sensitive to the person’s cultural needs.

“ U1 I guess it’s difficult, I personally have not got much experience in assessing people from different cultures, we live in predominantly a white area don’t we, not very culturally diverse but, language barriers and those kind of, on an assessment, when I have assessed people not in a Mental Health Act situation from other backgrounds it so much more difficult to add and put that extra pressure on as well with the language barrier and cultural understanding within an AMHP assessment situation is pretty difficult isn’t it, so would that

give rise to increased detention because of a lack of understanding and erring further on the side of caution than you would had you been able to have really good mutual discussion (participants agree).

X1 I was just going to say obviously that we have to accept as well, there is institutional racism within the whole structure and process as well.

Y1 not for everybody clearly, but I think sometimes obviously we all have our own values and beliefs, and we approach different assessments in a different way don't we. So, from the outset you're already bringing that to the table, so when you're assessing somebody that's going to influence the decision process.

“W1 well I was going today well if we think about the, you know, we accept that social factors like poverty and poor housing and unemployment and so on and so forth affect people's mental health then the fact that black minority , ethnic communities are far proportionally more impacted and more severely impacted then (participants agree) that would tend towards you thinking that people, those communities may well suffer mental, worse health and then have less access to preventive services and maybe less. “

The issue of the interpreting services was cited as a significant negative factor that could impact on the outcome of the assessment for people for whom English was not their first language. They collectively expressed the belief that this was a resource issue, and the quality of interpreting services especially when they were a phone rather than face to face service could negatively impact on the outcome of an assessment.

“W1 what I will say just with what (other participant) was saying about the language difficulty. This whole thing about bloody telephone interpreting (participants sigh) it is a disgrace.

S1 not having that consistent interpreter, I have a Polish family that I work with and I find it really difficult, they are already very suspicious of services and having a different interpreter every time is just awful. For them not to have the choice to say, no I trust this particular interpreter, I've built a relationship with this interpreter. For that not even to be an option.

T1 I was just going to say using the telephone service, it cuts out half of the assessment doesn't it, I mean that person can't see that person so they're not able to gauge whether what they're saying and the way the that their facial expression or body language is presented, so whereas you can't understand what that person is saying you can only understand their translation of what that person is saying you know, it's difficult.

W1 and you don't get, I don't feel that you get that same kind of quality of interpretation (T1- no) from the telephone interpreter. "

It was not just the beliefs and behaviour of people from other cultures that the participants believed were misinterpreted. The participants expressed the belief that unconditional acceptance of the medical model had possible negative consequences for everyone who is expressing or presenting with mental health difficulties. They spoke about the need to challenge medical assumptions and their own scepticism about the diagnostic process. They spoke about the existence of alternative views of mental health, such as the social model. However, they expressed the belief that this model of understanding had limited influence.

The belief was expressed that the medical model was dominant within society generally, which was seen as partially due to the influence of the pharmaceutical industry. But also, a more generally held view in society that a range of normal behaviours are medically driven or require medical intervention. There was also the view that this fitted with a wider ideological perspective that pathologised the individual's behaviour rather than addressing the wider social context. This again reflects the writers (Kutchins & Kirk, 2003; Pilgrim, 2014; Watters, 2010) who take a critical approach to mental illness. And also reflects the arguments of writers (Moncrief, 2008; Whittaker, 2002) who are sceptical of the psychiatric positive contentions about the efficacy of psychiatric medication.

"S1 It's fuelled by pharmaceuticals isn't it?

X1 in much as other areas of life are (S1- absolutely) you know people are having babies now it's become this medical thing, in the old days, like you said, there'd have been a woman down the road that could deliver the baby with minimum fuss. (Participants agree)

W1 It's much cheaper to drug somebody into submission than it is to change the social conditions that, (participants agree) that drive them to distraction. "

Participants commented on the possible causes of medicalising behaviour and the need to critically question medical approaches. The discussion describes how everyday behaviours can be misinterpreted once a label of mental disorder is attached to someone. There was evidence here of why the AMHPs use a counter-intuitive approach when considering assessments because they believe that all behaviours can become attributable to the person's mental illness once the person is given a diagnosis.

“V1 I mean just going back on about labels like, when I worked in (Previous employing authority) nothing was ever triaged it was a case of you got a referral and you had to deal with it. You either get something like this person has got schizophrenia he's been shouting at kids and you got to go out there and do a Mental Health Act assessment. Yeah, he is known to services and yeah, he has got schizophrenia the reason why he's shouting is that someone's been tying fireworks to his dog's tails you know what I mean. (Participants agree and chuckle) so it's not what's on paper it's what's been presented to you when you have to go out and knock on somebody's door.”

The AMHPs talked about how the medical view of mental illness was reinforced by mental health professionals including themselves. This was expressed partly through the diagnosis and treatment process but also in the way that AMHPs consider the criteria for detention. In other words, the framework of mental health legislation directs the AMHP down a medically framed legal process. The AMHPs express an alienation (Ferguson, 2017) towards this process, as being one that they are individually responsible for but something they do not control. It is described in almost classic terms of alienation as something that is controlled from elsewhere.

“V1 It's a case of giving someone a diagnosis or a label, (participants agree) so they throw some medication at them to actually suppress them.

S1 So we all fit into this normal person that we all should be.

Y1 And also even in terms of when you break it down you've got a mental disorder and that is all, often we see people with multiple diagnoses isn't it so it's like well, what's the

diagnosis, what's the mental disorder, what's the nature of that, what's the current degree and the manifestation of the condition and then working your way through the risks. It's very very medical driven. "

The inconsistency of the diagnostic process was also discussed and the AMHPs expressed scepticism about the accuracy of diagnosis as well. There is a strongly reflected theme here that concurs with the critical realist critique (Pilgrim, 2014) of mental disorder, in that psychiatric diagnosis is often tautological. Particularly in relation to the generally held approach in medicine which requires consistency in how symptoms are considered and used in diagnosis. The language they use to describe this process is critical of the medicalisation of mental distress but also expresses the belief that the power to do this lies with people other than the AMHP. The cynicism again expresses a feeling of alienation from this aspect of the decision-making process.

" X1 And I am always surprised that people don't question the diagnosis (Y1- yeah) I actively encourage people to ask, how did you come to that decision and what does it mean. Often, they have very difficult conversations with doctors because if we look through the notes there might be about five different diagnoses over the year. The notes are like that and when you get back to the beginning it's completely different to how it is now.

W1, I suppose medical model is often, it's the collection of the symptoms isn't it and the label you can stick on them. (Participants agree)

V1 So that you can throw medications at it. (Participants agree)

S1 Because it's easier to do that isn't it, it's easier to tick a box and say all these things, all these criteria are met therefore you fit into the schizophrenia box. And even sometimes we may do schizoaffective and try and cover both. But you can't just have somebody who is a bit eccentric or doesn't fit into a social norm.

W1 or they have a personality disorder (participants laugh) that's the other thing that makes me laugh is that everyone who used to be schizophrenic or bipolar is now personality disordered

S1 But borderline

W1 Borderline. BUPD (participants laugh) "

The participants did express the belief that there were alternatives to the medical approach to understanding mental distress and distressed behaviour. They explicitly named this as a social model of mental illness and described what they believed were the key features of this. This included acknowledging the experience of trauma and its impact on people's behaviour and other influencing factors such as oppression and discrimination. Participants expressed the view that although social models of mental disorder offer an alternative to a medical model, they were seen as secondary or less relevant. This could be as Schon (1991) describes, that medical science is held in greater esteem and that general hegemonic authority has been achieved by psychiatry and the pharmaceutical industry (Kutchins & Kirk, 2003; Watters, 2010; Whittaker, 2002).

“ Y1 A medical model for me is erm nature, you know, genetically predisposed to this bla didi bla. It's everything we've read; a social model is looking at what might cause those symptoms. Prejudice, racism, homophobia whatever in society that has impacted on that person. Childhood abuse, trauma to make that manifestation condition, that's the way I would see it.

T1 And the same can be used to cope with that condition, rather than the use of psychotic drugs.

S1 There has been some moves though hasn't there you know with like a social intervention, I think it's all sort of very lip service isn't it. But this sort of pretence sometimes that we look at and we obviously we do look at, that's where are roots are based, we wouldn't be what we're doing if our ethics weren't around people's home environments and how they choose to live but sometimes it just seems a bit token. “

The discussion about the inclusion of social perspectives is continued in the next section.

### 5.3 Social Causation

The participants reflected on how people's behaviour and presentation was not necessarily the manifestation of an illness or diagnosable medical condition. They considered how the person's presentation could reflect their circumstances or societal pressures, although they did not exclude the notion of these symptoms being considered an illness. They use the language of diagnosis which is a medical approach but seek to understand the causation in social factors such as individual influences and community disadvantage. The question of class is introduced when the AMHP describes the disproportionate pressure placed on lower income groups. The increased numbers of people presenting with mental illness was considered in the context of changing demographics and the disruption of community cohesion. The community the AMHPs predominantly worked in had been dominated in the past by the mining industry, some of the AMHPs had close associations with these communities either through work or where they lived. The AMHPs are describing structural changes in these communities and the changing culture of work and community life. Ferguson (2017) alludes to this in his description of how life for many has shifted from social solidarity to individualism. The AMHPs also contemplated the possibility that it was the changing nature of society and its impact on communities that was leading to increased incidents of mental health problems. They linked this to generational changes that are impacting more heavily on younger age groups.

" S1 Which is what you were saying about what leads to madness you know, we can look at like, schizophrenia, bipolar but there is a wealth of other things that lead you know, and how much of that is based around your own lifestyle choices or your community or your upbringing. Lack of lower level preventative stuff. (V1- yes)

T1 Depression, depression is the biggest one, (participants agree)

W1 What leads to utter desperation as well, (participants agree) and inter- generational desperation as well because it's that thing about upbringing isn't it, it's absolutely everything now that conspires against people having or developing decent, stable, long-term kind of resilience in mental health. You think about what's happening to children in schools, sorry I'm about to go off on one here, but you think about the pressure that children are under in schools, the pressure that parents are under in terms of you know, universal credit (participants agree) and the push to work 35 hours' even if you're already working 30 hours

and to evidence job searching. Now how does that promote sort of, good, attentive, responsive parenting. “

The AMHPs grappled with the double-sided nature of this question; on the one hand they questioned the medicalised approach society now takes towards everyday behaviour, whilst at the same time acknowledging that there may be a greater awareness of mental illness.

“ S1 Do you think that has always been there in some form, I mean I think the pressure is, I mean like you said the pressure now for kids and parents, being one parent, you know, its immense isn't it. And I just wonder. I wonder how much of that has sort of increased people's anxieties and. But there's always been pressure, you know you look at my grandma I suppose living through war, there's always been an amount of pressure and stress. Do we just kind of know more about it now, do we just put a label on something and that's what we've all got now you know. We have all got such stressful lives, we're all suffering with anxiety and depression. Did people suffer with anxiety and depression in the war but just cracked on with it cos it didn't have a label and a name. Do you know what I mean? Sometimes we just know too much don't we. “

They returned to the theme that changes in the economy had led to changes in communities that then impact on families and the individual. This perceived move away from collective approaches to welfare, including mental distress, was seen as a causative factor in the individualising and pathologising of people's mental distress. The individualising of people's inability to maintain good mental health and the sense that society was out of peoples control also reflected Ferguson's (2017) description of the way in which individuals become alienated from control of society but also alienated from each other.

“ W1, I think there maybe something about, sort of, collective experience though as opposed to atomised experiences and I think, you know, there is a lot about living in a much more atomised society now isn't there and the loss of community and collectively. (Participants agree)

T1 People are lonelier aren't they now, than they were before and even though you've got all this technology and Facebook. (S1- that makes things worse) But you know that's

talking to your friend now whereas before you would have a conversation, face to face conversation, you can see each other's emotions you can feed from each other and learn from each other and that sort of like takes a lot of stress away. I mean, I don't talk to anybody on a daily basis because I work with myself for myself so the only people I speak to are carers in care homes or somebody who's got some form of mental disorder or dementia or something like that, and there the people I converse with in my working life so I don't have anybody to, so every now and again when I go to a conference or something like that, that's when I sort of recharge my batteries cos then I'm learning what other people are doing that sort of thing. But children don't do that now, they don't know how to speak to each other.

V1 Yeah, but I think prior to that though what (another participant) was saying was, she mentioned being worthy of those community and the sense of community. Whereby community's you know there aren't that many big industries knocking about and as an ex-coal miner I don't want to go down that line but there was a sense of community where everybody used to look out for each other.

T1 Belonging

S1 But that looking after your own as well (V1 agrees) and I think again maybe that is something that we lack is that you know, we've stopped looking after our own and expect other people to look after. Nobody would disagree with that I don't think. There's a culture now that, I think, it's everybody, it's what you do for me, not what we do for each other isn't it. There's a massive culture around somebody else should be doing that for me.

V1 I think we've run away from the sense of community and looking after each other to I'm alright jack and sod you lot, you know. "

The impact of the changing structure of communities and societal attitudes was commented on, the belief that we have shifted from communities that supported themselves to ones that required external intervention. Again, this was seen as contradictory particularly in relation to the role of women. The belief was expressed that previously (It was not stated which particular era), communities were better at providing mutual support that reduced the need for specialised intervention, whilst at the same time there was a disproportionate effect on women who were expected to undertake the carer role. The discussion moved towards how different communities supported their members differently and that there were other family and community models that had different structures and support in place. The main point being made here would appear to be the increased medicalisation of

people's behaviour, described in a similar way to writers (Kutchins & Kirk, 2003; Watters, 2010; Whittaker, 2002) who believe that behaviours that are deemed to fall outside accepted norms are increasingly being given medical diagnosis.

“ U1, I think we have to look at the resources that are available for us, as we we're saying in a lot of ways now, that family support, that social support, that being able to support families to look after their own, is really struggling. So, in order to work from a social model, you would need to change society, wouldn't you? The society that we have at the moment (participants agree) that isn't supportive necessarily or that is struggling to look after yourself let alone your family. It's like a much wider issue than just saying.

T1 But it's like a circle isn't it, because like what you were saying before in relation to. We've been driven to produce more, give more, do more. But then on top of that because of that we feel that we want more, to gain more, to feel more. And then the people who are struggling, we haven't got time to help them cos we're too busy trying to (S1- gain more) get more because we're told to do more and gain more. So, all the time they're just sort of like left on the side. So that support and the community it's more or less gone hasn't it. (V1- agrees) I mean I'm from (A neighbouring large city), I've lived in and grew up in (The city), a big area and I knew everybody in my area growing up but now nobody knows anybody, you don't know the person who lives next door to you. (Participants agree)

W1 Or if you know them, it's interesting because I was brought up on an estate and my dad worked in the nuclear industry which was very much like the coal mining estate except it was nuclear. And people would come from all over the country to work in nuclear; it was very highly skilled workers pulled from everywhere. But, like you, I knew absolutely everyone on there and there were also, although most of the women, again similar to some of the coal estates most of the women didn't work, but there were always people round having cups of coffee and you would know if Mrs so-and-so was a bit down or if somebody's mum had died or a child was ill and stuff like that. And I do remember vividly, one woman it was kind of spoken of in hush tones that erm (whispers) Mrs So-and-so has had a bit of a nervous breakdown and she couldn't stop crying. And what happened was not that she went away to hospital, but all the women on the estate were piling in and sitting with her for a while and yet now ...

S1 in a way though we see that as progress, why should women be staying at home looking after children and the house, (W1- oh yeah!) do you know what I mean, but again that way I guess the hub of that support was generally around women that like you said didn't work. I've got young kids now and my mum thankfully has retired recently so she helps me with my childcare. But she retired when she was 62-year-old. I remember being brought up by my grandma when she was in her 50's. Would we want to go back to where? It's a really doubled edged sword (W1 agrees) It was different because there was that sense of community there. I remember everybody knowing everybody and going to my grandma's house and sitting having a cuppa and going to neighbours and sitting and having a cuppa.

W1 the contrast I was actually thinking of is, I now live in (Another local authority area) and I live in an area that has quite a few Asian families in it and most of my neighbours are Asian and actually I know those women really well, and it was really striking that when my neighbour on the left hand side lost her husband I went in for quite a while but other women from the community did. The white family on the other side of me can barely bear to say hello to me. It's really you know; they are so isolated. So, I also wonder whether there is a cultural kind of difference going on. (Participants agree). “

The AMHPs are commenting on the changing nature of communities and social attitudes which have led to the need to more formalised or statutory services performing the functions that would have previously been provided informally. This is reflected in the discussion in the literature (Pilgrim, 2014; Ramon, 2005; Szmukler, 2018; Warner et al., 2017) about the professionalisation of all healthcare, including mental health. The intended or unintended outcome of this, is that behaviour and its management reflect the dominant views of the agency assessing and providing support for people's needs. The AMHPs view here would appear to be that agency cultures reflect the dominant culture of society which is dominated by medical approaches and the dominant white British cultural norms.

#### **5.4 Resource-led Admissions**

The view was expressed that AMHPs were detaining people under the MHA because they did not feel there was a viable less restrictive alternative. The less restrictive alternatives included the availability of home-based support by community services or the availability of other resources, such as crisis houses or respite care. The pressure to detain people in hospital was also compounded by the belief

that, if there was a negative outcome (such as harm to self or others) following a decision not to detain, the AMHP would be blamed. The belief expressed was that the number of admissions may have risen because of the reduction of community alternatives. This included all resources and specialist resources that may be able to meet people's cultural needs. The impact of austerity and its disproportionate effect on vulnerable communities was commented on in the literature, (Davidson and Campbell, 2010; Ferguson, 2017; Furminger and Webber, 2009) this included the lack of in-patient beds as well as community alternatives.

" T1 Just in relation to kind of detaining people under the act, I mean it's just a question that I wanted to ask really, do people think that, if there was more support for a person outside would that prevent, what I'm trying to ask basically is are more people than necessary being detained under the act because of the services.

S1 Yeah, I'm sure, I think so

T1 I'm just wondering about, so we've got crisis team, but their availability is, you know??... So, does that influence you when you're doing, you know, carrying out a Mental Health Act assessment on the person. You know what support is available for that person outside and if there was more support.

S1 Well it does though doesn't it, if you look at the least restrictive option, if that's not available then you have a decision (T1- you do, yeah), a decision to make don't you.

T1 No I agree but I think there is a threshold for everybody in relation to risk.

V1 Yes

S1 Yes and that's subjective

T1, I think in order for that person to be able to, be accountable for their actions then they have to think about what would happen if.....? "

The AMHPs expressed the view that, although they did not see detention as a positive or even necessary option, they were concerned that because of lack of community alternatives, harm was more likely to occur, and they could be blamed for this. They were not specific about who this blame would come from although this belief is consistent with findings from the literature (Campbell &

Davidson, 2017; Pilgrim, 2014; Ramon, 2005; Szmukler, 2018; Warner et al., 2017). The AMHPs described wanting to take risks and feeling more confident about that decision if the appropriate support was available.

“ S1 And people are afraid of this sue society (Meaning culture of litigation) as well, where if you do something, like, you take somebody's bike you're going to get sued. Or you make a decision, relating it back you make a decision you're going to get sued you know that's something that hangs over everyone, that blame culture.

T1 Yes, for example, you don't detain and then something happens with that person, you know, if there were more services it would prevent that person or may prevent that person would you be more likely to a risk and allow that person to be supported in the community even if they're quite ill.

X1, I think earlier on when I was an AMHP, I think I'd only been an AMHP for 6 months, I disagreed with two doctors and I had a couple of sleepless nights because people were saying, I think you even said it (name removed), two doctors have signed those papers, what happens if. (T1- yes) And it was quite worrying, what happened if. Luckily, I was right. The person went home and as I got to know them, I realised that was just their personality that we'd seen as madness. So, it was an interesting time, and it gave me more confidence really for the future. “

The view was also articulated that the situation had become more difficult due to service changes and reductions in provision. The AMHPs describe feeling able to make decisions that are not risk averse if they are able to share those risks with other colleagues. They describe how they have increasingly started to feel that a lack of options has pushed them towards deciding to detain someone. They acknowledged that the decision-making process had become increasingly individualised and subjective, decisions not to use compulsory powers could come down to the experience and confidence of an individual AMHP. This was not stated as being due the AMHP's individual level of experience alone but included other factors such as the level of support they felt the person could receive from other service provision.

“ U1 Right, because I know initially, I worked in assertive outreach when it first began, and I know that when they looked back and researched the evidence there it was that that model was seriously reducing hospital admissions. (V1- yeah) And to have that back up, even if you had two medical recommendations and to have the backup of the assertive outreach team makes a big difference to what we’re kind of up against, more now doesn’t it.

X1 and at that time as well we had a lot of other resources, so we could put people into respite or you know, instead of now it’s either family or A&E isn’t it otherwise.

U1, I had a lot of support workers

V1 There were rehab wards as well weren’t there

S1 Your options seem to be very limited, it’s either, it is kind of detention or not, isn’t it? (Few agreed) sometimes that, there’s a major gap between what could be done in-between that decision but there isn’t that option. So, it is sometimes as simple as to detain or not (participants agree) and again I think that is very subjective depending on who, whatever each individual’s sort of threshold for risk is and dependent on what their experience of being maybe when they’ve taken risks or not taken risks. (Participants agree) “

The discussion also revealed how the AMHPs saw the disproportionate effects of cuts in services as having a greater negative impact on people from BME and migrant backgrounds. This took the form of a lack of support services available that provided an alternative to detention. The lack of good quality interpreter services and the inconsistency in these services were also cited as factors making life more difficult for people experiencing mental health difficulties.

“ W1 (Neighbouring local authority) used to have the black resource centre didn’t it, the black mental health resource centre that was it, and erm that used to offer counselling and social support and so on and so forth and was well used, and again that got closed down because the funding was pulled, you start to think, well actually what are people left with and are people you know ending up being detained for the lack of an alternative. (Participants agree)

S1 not having that consistent interpreting, I have a Polish family that I work with and I find it really difficult, they are already very suspicious of services and having a different

interpreter every time is just awful. For them not to have the choice to say, no I trust this particular interpreter, I've built a relationship with this interpreter. For that not even to be an option. "

A lack of understanding other people's cultures and misinterpretation of culture was also something AMHPs felt they themselves were responsible for, the idea was expressed that the AMHP service itself should be more diverse as it does not represent the demographics of the communities that they work in. The belief was also conveyed that this lack of knowledge can lead to stereotyped beliefs developing leading to assumptions being made about certain BME communities. This appears to contradict in some ways the previous beliefs that had been expressed about BME communities being more inclusive and supportive. They are questioning the possibility that for good or bad reasons some communities may be suspicious of statutory mental health services. These comments highlight the issues of cultural competency that writers (Campbell, 2010; Hatfield, 2008) have alluded to in mental health practice and the often-complex considerations that need to be embedded in practice.

" X1, I think that can sometimes be a myth in the Asian communities, that everybody, we always say they look after your own. It's not always the case (S1- no), I've worked with some families that are quite isolated because of their mental health (V1 & S1 – yes) and the rest of the community...

S1 Quite ostracised can't they. (X1- a little bit yeah) I think the stigma can sometimes be far worse (participants agree) from what I've experienced from Asian communities.

X1 There's also an issue, for me, that the workforce does not represent people's communities. We need to address that through equal opportunities, writing policies and procedures and so forth but we don't really address them.

V1 Lip service to it. "

## **5.5 Patient-driven Admissions**

The AMHPs expressed the belief that there were situations where the person being assessed wanted to be detained in hospital and left the AMHP with little choice other than to detain them. They expressed frustration about this, some of which was expressed in the form of humour. They

articulated the notion that a particular group of people who tended to have a diagnosis of emotionally unstable personality disorder was more likely to behave in this way. They suggested that this group not only sought admission but also worked collaboratively as a group to secure admission into hospital. The underlying reason for the services users feeling the need to do this possibly being linked to the reduction in community resources caused by austerity (Davidson & Campbell, 2010; Ferguson, 2017; Furminger & Webber, 2009), it was also be linked to deeper issues relating to the nature of mental illness for this group, which traditional models of mental health care are unable to address (Pilgrim, 2014; Watts & Morgan, 1994; Whittle, 1997). It was intimated that the patients understood the risks thresholds that the AMHP and others assessing were working to and intentionally increased concerns to the point at which the AMHP had no choice other than to detain the person.

“X1 on the other hand we do have people who want to be admitted (participants agree) like you just said. And they now know how to play the game (participants agree) I’m saying that because I know these people I’m not just assuming. They know what to say to have an admission to hospital because of the risk factor people are scared of not admitting them. They get into hospital. At the moment on one of the wards there like a little group that are running the ward. It’s not the staff running the ward it’s the patients. (Participants agree).

S1 and I think there are times when I’ve not been in that experience just yet but I’m sure it’s on its way, but one of my service users who is currently in hospital leaves you absolutely no choice but to look at a detention. Like you say, says the things that you have to respond to legally, you have to respond to because it is set in black and white in the Mental Health Act that if someone is a risk to themselves or a risk to someone else. “

The AMHP is articulating here the belief that, on occasions, the service user drives the decision to detain by emphasising the risks they present, which also emphasises that risk is the significant factor in the making of decisions. It would also suggest that there are occasions where the AMHP decides to detain based on the possibility that blame will be attributed if harm occurs, even though the AMHP believes that they are being pushed towards detention when immediate risk of harm does not exist.

When asked why they believed this group behaved in this way, the AMHPs acknowledged that it was partly due to lack of alternatives to detention and the service users were essentially doing the same

as AMHPs and opting for detention because of a lack of alternative community support. This initiated a discussion about the degree of autonomy that service users should be given in relation to having the capacity to understand and assess their own risk. There were elements of this that reflected the discussions of Tew et al. (2012) who looked at the impact of power relationships in mental health decisions. This challenge for the AMHP was discussed in the context of whether certain diagnoses should be excluded from the MHA. The AMHPs expressed the belief that detention into hospital for this group or informal admission was not always helpful and could reinforce negative coping or help seeking strategies. The lack of safe alternatives to detention that could meet the specific needs of this group outside of hospital was raised,

“ U1 we’ve never had any crisis house services in (local authority) have we. I think if we would have had that resource somewhere along the line people would be far more accepting of going to something, a facility like that, because when in an assessment situation if you’re talking about hospital admission, of course people will avoid that at all costs but if there were lower level acceptable, I think it would just be, well it goes without saying, it would be full without a doubt. “

This would suggest that the AMHP would seek an alternative to detention, if such an alternative existed. The phenomenon of patient-driven admissions was further explored in relation to lack of community alternatives and the possible need for different approaches for different people. The context of the discussion here is the AMHPs were grappling with a group of service users who they feel are driving their own admissions and then negatively dominating the culture on the in-patient wards to such an extent that the ward environment becomes unsafe or lacking therapeutic value for patients. This leads to the opposite dilemma in that the AMHP does not feel they can detain someone who requires admission because the admission would create more harm particularly for the naïve patient.

“ X1 but if there was somewhere else for these people to go other than hospital.

U1 or where the alternative people could go because we know, we’ve got insight into what’s happening on those wards and who’s running it now, and it’s not the staff this week, and then we’re assessing someone that’s first time admission, (S1- yeah absolutely) never

been through this system before and we know where we were sending them and we've got no alternative and no community support. "

The group were asked to define the group of people they were referring to, also to explain the reason they were driving their own detention. The participants reflected on the negative perceptions this group had of themselves and the negative feelings their behaviour can invoke in practitioners. They proposed the idea that, however negative an outcome a hospital admission felt for them, as practitioners, for the patient it met a psychosocial need that was not being addressed elsewhere or the model of intervention being applied was built on a misperception of the needs of this group of service users (Pilgrim, 2014; Watts & Morgan, 1994; Whittle, 1997).

" S1 ..... members of the suicide squad, that's what they've named themselves

S1 I think a bit of gang culture (participants agree) think it is your right. That nails it really

Facilitator So, why would people want to be in hospital?

X1 that is the questions I've got about the person I'm dealing with; I'm trying to find out really.

S1 I think it comes down to a particular group of young women with a very similar experience, background history, you know, significant childhood events that have found (V1- substance misuse, alcohol abuse) a niche, and a very unhealthy friendship group and support group. (Participants agree)

W1 well I was going to say the hospital becomes for them a relatively safe space and supported space compared with the outside world and I think you know in terms of the significant childhood events that can be really important because it does fill a gap.

V1 I had a visit prior to when I came here, and I saw one of these relatives and they were saying that they had a traumatic week, is there any chance you could find me a bed at (local psychiatric hospital) at least there's three meals a day and its warm and there's a roof over my head you know and I'll be looked after."

The AMHPs are expressing an understanding of how gaining admission to hospital has become a coping mechanism for some groups of patients. They emphasise the group culture that they believe pervades this process and the benefits this group derives from being psychiatric in-patients. The participants were then asked why, as AMHPs, they would facilitate admissions in these circumstances. The issue of risk was expressed as the primary reason and the external pressures they felt were applied to the process either from family or agencies. The AMHPs expressed the belief that it was unlikely in most instances that most of these individuals would intentionally kill themselves. A psychiatric admission in these circumstances is not of therapeutic benefit and is more likely to reinforce what they believed are negative coping mechanisms. However, they identified an inherent risk to the patient through the behaviours used to secure an admission, which could lead to serious harm to the person because of miscalculation. The AMHPs stated the concern that others would not understand the nuance in these types of decisions and blame the AMHP if the person experienced serious harm. This issue of blame identified by writers such as (Ramon, 2005; Szmukler, 2018; Warner, J et al, 2017) is picked up in the discussion.

“ X1 it’s often that they are very very high risk, the things there doing could inadvertently kill themselves basically

S1 and other people, not with an intent or wish to harm other people but as a result of their actions. Walking on M62 in the middle of the night, you’re certainly a danger to yourself but you’re also a danger to other people aren’t you, so that inadvertent risk to themselves and to other people. And it’s like ah say, sometimes, I mean I feel, I’m not talking for everybody, I feel; that you are given little choice. There isn’t a choice. Well there’s always a choice isn’t there but to take the risk and for me to personally take that risk to say I’m not admitting that person despite all these categoric risks and knowing that this person has significantly self-harmed in the past has caused themselves some significant and serious long-term damage. I’m not going to say no.

X1 and also, you’ve got the families, the families that are kind of pushing for admission (S1- yeah pressure) “

The AMHPs are acknowledging that real harm may occur through miscalculation, even though this is not the intention of the patient. As before, they are expressing the belief that, in these circumstances, the patient is escalating the risk concerns with the intention of securing hospital admission. Agencies

and families may then hold the AMHP accountable for this, even though there was no intentional causative nexus between the mental disorder and the harm that occurred. They took this discussion a step further and asked themselves how far they should interfere in the freedom of choice of an individual to harm themselves. Here the question of capacity is raised and the question of autonomy for the person in deciding their own outcomes. The AMHPs acknowledged that it is when a person brings their suicide into the public arena, then, as a public authority, they are given the duty to act in relation to keeping the person safe.

T1 that's exactly the point. (S1- your right absolutely) when you've got somebody who consistently coming every three months saying 'I'm going to kill myself, I'm going to kill myself' because they want to be in hospital because they might have friendships in there or whatever.

U1 but sometimes they actually want to kill themselves.

T1 yeah, they do, you know you've got people ... that's a good point... but I think the thing is, I mean you've got people who go to Dignitas to kill themselves and we don't detain them. We don't detain people who want to kill themselves in any particular way, but it's when a person is going to do it in a violent way, that's when we.....

..... if you can decide that you want to end your life, this, it's a question not a statement, but if you can decide that you want to end your life does that mean that you should be detained under the Mental Health Act?

W1 it's a problem in when their desire to kill themselves is something that is publicly manifest as well isn't it, so, erm, I guess if people go to Dignitas it's a kind of private, self-managed process that can be completed, (T1- you're doing and your taking yourself to do it) whereas the people that we are struggling with in this way, appear to be ambivalent because they are taking overdoses, or swallowing razor blades, or whatever and then coming for help (participants agree) at that point that is really problematic for us, even if there saying well I don't want to come into hospital I want to kill myself and so on and so forth. The fact that they have presented or presented for help.

S1 it's that fluctuating I want to kill myself, but actually I don't want to kill myself I want support, but I don't want support I want to kill myself (participants agree), and that constant fluctuation. "

The AMHPs returned to the original question, which was “Do we need a Mental Health Act?” and extended that discussion to how far the powers of mental health legislation should go. The legislation they are working with allows for the detention of people who have capacity to understand decisions with regard to risk to themselves or others. They are prevented from acting on their expressed wishes because they have a mental disorder, even though others who wish to end their life, in some circumstances, may be allowed to do so. This debate about the person’s right to life is centred on their competing obligations as public authorities in relation to human rights legislation, articles 2 and 3 require them to protect the person from harm, article 5 and 8 require them to act proportionately in relation to restraint and the person’s privacy. The question of the person’s decision-making capacity, their right to autonomy and the expectations of contradictory legal guidance (Allen, 2013) is being debated here.

The participants questioned the purpose of ongoing in-patient admission, as per the principles in the Cop/MHA, following which a further discussion about autonomy and capacity with regards risk to self then developed. The AMHPs questioned, based on the previous discussion, if certain groups should be excluded from the MHA if there were no clear therapeutic benefits to admission or whether they should have autonomy in decisions that involve risk or harm. The general view was that this would in itself be discriminatory against certain groups experiencing mental health problems and the real problem was the lack of other viable alternatives. Interestingly, no-one picked up on the point raised in the CQC report (CQC, 2018) that one of the possible causes of increased detentions may be the inclusion of personality disorder into the MHA when it was amended in 2007.

“ T1    What if we talk about that in relation to learning disability?

S1    I think it does have, I don’t think you can sit there and say that somebody with a personality disorder should not be detained in hospital. Because then you are just making a broad sweeping statement about a group of people with a certain diagnosis without looking at the social, the background, all the other factors that have a massive impact on that. So, I think that’s too much of a broad statement. And I think hospital admissions for certain types, certain individuals do maybe offer that respite that needed out of a particular situation for that certain amount of time. I also think that there are some people who are able who can use it as a gatepost to therapy or, I think there are also other individuals who will constantly be that “revolving door” and will get no therapeutic or health value from being detained.

W1 and part of the problem is the absence of alternative (participants agree) and genuinely therapeutic services. I mean for a time there was, certainly in (Neighbouring local authority), there was the dialectical behavioural therapy (S1- absolutely) service, yeah and there were entire teams trained in it and you could be reasonably confident that somebody who actually wanted to engage or even if they were ambivalent about engaging, they could actually get some benefit from it.

S1 we had that in (local authority area) didn't we and then it decommissioned and now we have no DBT, which is NICE guidelines for treatment of people with EUPD so within (This locality) that resource which is recommended in NICE guidelines isn't available. So, we're already on the back foot aren't we (participants agree).

S1 it's just about, look at the closure, just from our team, look at the closure of (named patient led drop in service) and the amount of admissions we must have had on the back of (named patient led drop in service) closing. Which you know, it had its faults but encouraged people to just sit and have a chat together, and there was a lot of problems there but actually there must have been a number of admissions just on the back of (named local service user led service) closing down. "

The AMHPs response suggests that, despite all their difficulties and concerns about certain groups of patients, they were concerned that exclusion of these groups would lead to a discriminatory approach. They state that, although not ideal, admission can provide the opportunity to start the process of finding other help. They also point to admission as a secondary alternative to services they believe should exist. The phenomenon of patient-driven admission was also considered in the context of service user choice. This is expressed as a reflection of the pragmatic decisions that AMHPs have to make with regards to alternatives and in the absence of more positive choices service users will seek alternatives that make them feel safer. This picks out some of the points made by Tew et al. (2012) regarding the need for people experiencing mental health difficulties to have a degree of control over what is happening to them.

" W1 this is kind of slightly tongue in cheek but the thing that struck me about people arranging admissions via Facebook was that's almost like a user led crisis service isn't it. And actually a user led crisis service again in (Neighbouring city) it has a user led crisis service that does provide erm you know temporary respite for people but is also really clear about,

you can't stay here forever and ever you are here for a time and then you go back and I think because its user lead there is a force to that because nobody can say oh you don't understand, you don't know what it's like, people do know what it's like and it's on the basis of knowing what it's like that they are saying that.

U1 just from what (other participant) said, it's kind of more of empowerment isn't it. People doing a user led erm crisis service, it almost turns around here because they've got no, there's no power, on the ward they are creating their own by causing all the chaos that's on their rather than channelling it positively. In that model, we've got what we got. "

This issue of power and relationships is reflective of a number of writings (Pilgrim, 2014; Watts & Morgan, 1994; Whittle, 1997), it has strong echoes of the issues raised by Tew et al. (2012) with regard to the need for more collaborative approaches to the service users distress that empowers the service user rather than further compounding the oppression and stigma they experience.

## **5.6 Conclusions**

The focus group reinforced some of the main risk themes from the interviews and gave an insight into some of the decisional factors identified in the process of considering and undertaking assessments. The two sets of data concur on the finding that the AMHPs see their role as primarily sitting within a legal framework. The strengths of this are identified as a protection against arbitrary detention and the guarantee of some kind of minimal support with mental distress at the point of acute crisis. The AMHPs in the focus group reflected and developed concerns in the interviews about the dominance of medical approaches, which they identified as arising from the ideological dominance of these beliefs in society which are reflected and reinforced by the legislation.

The issue of resources and alternatives to detention is much more evident in the focus group discussion which probably reflects a much wider scope of assessments beyond the issues that were raised in the vignette. This included people who are maybe seeking admission rather than avoiding services and situations where the risk to self is accompanied with a greater degree of decisional capacity and therefore potential for autonomy. The frameworks identified in the interviews are evident in the focus groups such as legislation, risk and accountability. The AMHPs were much franker

in the discussions about how these issues may impact on them individually. These themes are now picked up and discussed in relation to the literature and the findings of other research.

## 6.DISCUSSION

### 6.1 Introduction

This research has sought to gain an understanding of the decision-making processes of AMHPs and the factors that influence the requests for assessments they consider for people living in the community at the time of the request. The critical realist perspective meant that the study was premised on the belief that there would be evidence of frameworks of understanding AMHPs use when making considerations and it would be possible to identify factors they take into consideration when considering or undertaking assessments, the aim of the study was to identify these frameworks and the factors contained within them. The theoretical position proposed at the beginning of the research was that *the process of AMHP decision-making involves a range of objective and subjective elements which interact with the beliefs, values and experiences of individuals to inform and influence the decisions that are made in respect of mental health service users*. The use of a critical realist perspective has enabled me to consider a whole range of variables with a unifying perspective that draws together the various elements impacting on the process. This includes a consideration of hegemonic ideology around the question of mental illness, the structural factors of law, political economy, oppression and the personal way in which the individual AMHP negotiates all the elements of the process including its implications for the participants.

The use of a bounded case study with multiple participants using a single vignette has allowed comparison of the decision-making processes of individual AMHPs. The comparison of the decisions made has identified similarities in the pattern of decision-making as highlighted above. The critical realist perspective that theoretically underpinned this research is used in the discussion to consider how the more intransitive elements of the decision-making process such as the legal framework interact with the more transitive elements of AMHP decision-making including concepts of mental disorder and the construction of the risk agenda in mental health work.

The themes identified in the findings will now be considered in the context of the literature review and within the conceptual framework of critical realism that was adopted. The findings of the interviews and the focus group will be integrated and synthesised within each section.

## Summary of Key Findings

1. That AMHPs do use frameworks of understanding during the consideration and undertaking of MHA assessments. These frameworks are boundaried by the legislation but are influenced more by subjective factors including the dominant agendas of risk and the medical approach regarding concepts of mental illness.
2. The way that AMHPs construct and deconstruct their frameworks of understanding incorporate critical realist perspectives about mental illness and the related risk agenda. A strong theme particularly in the focus group discussion was the AMHPs' view of mental illness as a social problem as opposed to a purely health problem.
3. The decision process is dominated by the consideration of risk however, this is not based on prescriptive risk assessment tools. There is commonality in the factors that AMHPs consider and the way in which they are considered, a major element of this being the deconstruction of risk narratives presented by others. The AMHPs also use similar practice tools for deconstructing these perceptions of risk.
4. The legal decision making of AMHPs is not arbitrary; there is clear evidence that all the decisions taken matched with the legislative framework either explicitly or implicitly.
5. AMHPs differentiate themselves and their roles from other professionals in the decisional process. They identify a unique role they believe they undertake, whilst understanding that it is not a standalone responsibility they hold.
6. AMHPs express their belief that their role is as an independent decision maker whilst at the same time they cite a range of variables which impact on their decision making that are out of their control.

### **6.1.2 Contribution to Knowledge**

The findings of this research are original for a number of reasons firstly, although they have similarities with other research with regard to focusing on the decision making of mental health professionals and the consideration of dominant factors such as risk. This research focused on the decision making of AMHPs specifically when undertaking a unique role in the context of the MHA. Previous studies that looked at the totality of this role focused on the previous role of the ASW. The other research that was scoped relating to the role of the AMHP considered component elements of the AMHP but did not attempt to set this in a general context.

The critical realist approach adopted for this research and the use of the case study approach enabled the consideration of the whole process of an assessment. The apriori theory that AMHPs like other professionals would use frameworks of understanding and the use of a single vignette to test how individual AMHPs considered the same scenario allowed these patterns and schematic themes to be identified and analysed.

The interviews identified the micro decisions that AMHPs make and why they make them. The macro issues of dominant cultural beliefs about mental illness and the associated risk agenda were explored in the focus group and were analysed in the context of the ideological concepts of mental illness and associated risks. This research identified a theoretical positioning by the AMHPs as critical realists in the way they perceive mental illness, its causation and strategies for managing its impact on the individual and society.

The unique perspective of the insider researcher enabled analysis of the material and the interpretation of underlying themes that would have not been possible by the naïve researcher. The research contributes to a growing body of knowledge about the decision making of AMHPs and provides an overall framework of understanding about his field. The critical realist approach enables the application of these findings to the AMHPs own use of critical reflective practice.

### **6.3 AMHPs use of Frameworks of Understanding**

This research suggests that this group of mental health professionals are using frameworks to make sense of the requests they are dealing with. The concept of frameworks identified in the literature (Strachan & Tallant, 1995; Russo & Shoemaker, 1992; O'Sullivan, 2011) relating to the decision-making of social workers and other professionals puts forward the proposition that as decision-makers we use pre-designed templates that enable us to understand and predict social situations and the behaviour of people within those situations. The evidence suggests that at each stage, the AMHPs used frameworks for understanding and making sense of the person's behaviour, using critical tools to consider the possible presence of mental disorder and any associated risks. The analysis of the transcripts identified similar themes across the interviews which included the consideration of the

criteria for compulsory measures and the principles of the MHA. The *least restrictive and maximising independence principles* (These principles are fully described in chapter 1) being the most explicit in their expression with other principles being more implicit. The way in which the frameworks were populated, and theories constructed from this, gave further insight into how AMHPs consider and progress through the process of decision-making.

The evidence suggests there were distinctive phases of decision-making. Firstly, whether to undertake a formal MHAA, leading to how the assessment should be conducted and finally the outcome decision following a formal assessment. These decisions flowed from the information gathered in the first phase which was processed with a view to ensure the legal and safe conduct of the assessment and with consideration as to how the assessment process could positively or negatively affect the outcome. This was an example of how stages in the process were linked in a chain leading to the possible decision to detain someone and deprive them of their liberty. For example, there was consideration of the increased risk of a negative outcome for the service user if the assessment itself is not managed sensitively. This evidenced that the process of consideration is reflexive and the way AMHPs weigh and apply factors can affect the outcome. The review of options is based on hypothesis building, testing and reviewing. This is not a one-off event but occurs repeatedly throughout the assessment as the AMHP receives new information.

The evidence from this research supports the view that the frameworks and considerations that AMHPs use are broadly in line with the legal criteria and principles for considering compulsory detention laid down in the MHA and its code of practice. The frameworks relating to these process elements of an assessment were more identifiable in the evidence drawn from the semi-structured interviews, these frameworks included the legal framework and the associated framework of risk. The consideration of risk was a clear theme within the general legal framework that was being applied and informed a large proportion of the decisions going forward. The other significant theme was the AMHP's view of themselves as having professional roles distinctive from others which generates for them additional personal conflicts and dilemmas. The beliefs and values frameworks were most evident in the focus group discussion, this also included the framework of risk which was discussed critically in relation to underpinning ideological beliefs about mental illness and the culture of risk. It was in this process of deconstructing the question of the necessity of mental health legislation that the AMHPs demonstrated a deeper ideological questioning of the role they undertake.

The research confirms that AMHPs use frameworks of understanding that shape their considerations during MHA assessments. These are previously developed schemas boundaried by the MHA criteria for detention and its CoP. The statutory considerations of mental disorder, its nature and/or degree are dominated by another framework of understanding, that of risk. In developing understanding of the decision-making process further, AMHPs are most explicit about the consideration of the mental disorder, nature and or degree criteria and the least restrictive principle of the MHA while other principles of the MHA influence responses in more implicit ways.

The use of frameworks primarily built on the legislation and the AMHPs primary focus on this and the explicit adherence to principles directly related to the AMHP contribute to an understanding of how decision making could be reframed by legislatures.

#### **6.4 Considering Mental Illness and Mental Disorder**

The MHA is premised on the underlying belief that there is such a thing as mental illness or mental disorder and that these mental states can be identified and medically classified. The evidence situates the AMHPs in this study more as critical realists rather than positivists or constructionists when it comes to this consideration. There was an acknowledgement that mental distress was a real experience for the person, whilst at the same time it was clear that the AMHPs were taking a critical view of many of the medical diagnostic assumptions of other professionals, particularly psychiatry. There was also evidence that a range of elements including their own beliefs/experiences and interactions with other professionals were part of a dynamic construction when interpreting a given situation.

The MHA permits the detention of an individual on the grounds of mental disorder alone (Jones, 2019). As highlighted by Rapaport et al. (2009), the criteria for detention includes nature and/or degree of mental disorder, therefore, the pre-existing diagnosis of mental illness, defined in the MHA as the nature of a disorder, could be deemed enough to warrant an intervention against someone's will, even if there are no acute symptoms at the time of assessment. The decision to detain on this basis alone without additional factors would therefore indicate the AMHP's adherence to a purely psychiatric positivist view that isolated the person's diagnosed condition from other contextual and social factors. This study found however, that the AMHP draws on a complex interplay of subjective, objective, contextual, ideological, historical and material factors and is not guided by the medical/legislative

framework alone. In the following sections, some of these factors are delineated to show their significance to the decision-making but this is not to give the impression that they were considered in isolation from each other.

Information about the person's clinical history featured strongly throughout the process of consideration and assessment. This was a factor in relation to the decision to assess under the MHA, how the assessment would be conducted and on the outcome decision. In deciding whether to undertake an assessment there was attention given to whether the person would possibly meet the criteria for detention, mental disorder being one of the criteria. The person's clinical history was also used to confirm if there was an existing diagnosis and what risks had previously presented that may match the current presentation. Glover-Thomas (2011) noted that the previous psychiatric history was a significant influence leading to a greater likelihood that people would be re-engaged with mental health services. This previous finding is partly supported by the AMHP's enquiries about the person's diagnostic history and their attempts to build a picture partly based on this information. Although re-engagement in this study did not necessarily mean detention in hospital, alternative or counter-intuitive ways of considering the situation were applied and less restrictive or less medical support to the person was considered and proposed.

The previous diagnosis and associated symptoms were considered and matched against current behaviours, as a way of confirming or eliminating the presence of mental illness or current risk. This evidence is partially supportive of the view presented by Glover-Thomas (2011) that past behaviour is considered as a significant predictor of current risk. Although the AMHPs in this study considered diagnosis and symptoms alongside current contextual factors such as substance misuse before proceeding towards any decision to assess or detain.

In all cases the AMHP deconstructed the information they were given to seek alternative explanations and solutions. It needs to be noted here that the study by Glover-Thomas (2010) included a range of mental health professionals and therefore the differences identified here may be due to this study being exclusively AMHPs. One example of this was that Glover-Thomas (2011) considered the possibility that the pragmatic rather than formal processes of legal decision-making in mental health created the possibility of the assessors pre-determining the outcome of an assessment based on the

person's previous history, particularly if they have had long and tempestuous psychiatric history. This was not evident with the AMHPs I interviewed.

The place where diagnosis played its most significant role was at the end of the process of assessment when a decision to make an application for detention had been made. A decision then takes place about the use of either Section 2 or Section 3 of the MHA, section 2 is for a period of up to 28 days, the primary purpose of which is assessment, section 3 allows for detention up to 6 months with the primary purpose of psychiatric treatment. The AMHPs took into account the person's previous diagnostic and treatment history in order to determine if the primary purpose of detention was assessment or treatment. If there was a pre-existing diagnosis of mental disorder and the current presentation or symptoms did match a previous presentation, the AMHP was willing to consider Section 3 rather than Section 2. There was also evidence that the consideration of section 3 was more likely if another detention had happened recently. This could partially place the AMHP within a psychiatric positivist view of mental disorder as a decision to seek treatment rather than assessment suggests the AMHP has a belief that hospital can provide medical treatment for an established illness. There were some AMHPs who stated the belief that re-establishing treatment was important, although the dominant views expressed about the benefits of admission were primarily related to the person's safety, the safety of others and the re-establishment of social relationships.

In relation to professional roles under the MHA, the responsibility for establishing the existence of mental disorder (nature) and any associated manifestations or acuity (degree) rests with the assessing doctors. It is evident that, despite this formal distinction, the AMHP still considers the possibility or otherwise of a mental disorder being present. This deliberation by the AMHP was part of the process of deciding if a formal assessment should take place. Prior to contacting a doctor, the AMHP considers if a mental disorder is present and if the person is potentially going to meet the criteria for detention or intervention. Although the consideration of medical factors appears to sit outside the role of the AMHP they saw it as an essential element of ensuring their perceived role was fulfilled, in this instance the role they see themselves as fulfilling was the considering all factors of the case. This could be seen as the AMHP trying to usurp the power of the doctors because if the AMHP did not believe that the presenting symptoms constituted a mental illness or there were no associated risks, the AMHPs showed an awareness that they could stop the process before a doctor became involved.

Another example of this expressed recognition of their independent power was the way the AMHPs described their critical role in assessing mental disorder, by ensuring that the person was interviewed in an appropriate manner. This was partly practical (i.e. for purposes of eliminating the possibility that the behaviour is caused by intoxication) but was also ideological, ensuring that the identification of mental illness was not attributable to a person's cultural beliefs or customs. The importance of good interpreting services and the AMHP's own cultural competence were identified as essential when seeking to contextualise behaviours that could be a reaction to the person's circumstances. What also became evident in the focus groups was that there was a deeper ideological mistrust of the medical/diagnostic approach which they tested through their questioning of the medicalising of behaviour. This critical approach was reflective of a range of writers (Kutchins & Kirk, 2003; Moncrief, 2008; Watters, 2010; Whittaker, 2002) in the literature who have developed critical perspectives of the psychiatric positivist view of mental illness and suggests that this group of AMHPs retain a strong commitment to a social perspective of mental illness.

This critical approach does not isolate the AMHP as they acknowledged that other actors in the assessment procedures have specific roles and different perspectives. They explore the evidence presented by other health and social care professionals and also consider evidence presented by the family. Different weighting is given to the evidence dependent on professional status and AMHP knowledge of the person. Although family members are often not healthcare professionals, their opinion is considered as valuable as that of the GP in that the family has prior knowledge that can contextualise the person's behaviour. This was an indication that the AMHPs were applying non-psychiatric perspectives to their analysis of the situation. Part of this process was the introduction of motive factors when they questioned the reason for the request being made or why the person making the request held the view that they did. By doing this they acknowledge that (like themselves) others are subject to internal and external pressures objectively and emotionally that have an effect on their perspective of a situation. Essentially the AMHPs were calibrating the perceived presence of mental illness and risk by considering the unique viewpoint of the person offering the information.

Although the identification of mental disorder is not explicitly identified as an AMHP role, the scrutinising of medical recommendations would suggest there is an expectation they will challenge medical opinion when the medical evidence is lacking or inconsistent (Jones, 2019). Evidence of how the AMHP does this in practice was shown in the way they sought to establish if there was a relationship or causative nexus between mental illness and the concerning behaviour. In legal

language this would be described as the nature and/or degree of a mental disorder. In simple terms they are asking if the person's behaviour is eccentric/unwise or is their behaviour the manifestation of a mental disorder. When a causative nexus is identified, the AMHP then considers perceived risks arising directly from the mental disorder and its manifestation. This could be partly described as the AMHP applying a counter-intuitive approach to medicalised approaches to mental illness. This formulation of assessing risk and potential concordance with any proposed plan could also be described as a formula of 'mental disorder plus risk', consistent with the process that Szmukler & Rose (2013) identifies as unchanged in mental health for the past 200 years. The AMHP is bringing critical scrutiny to bear but only within ideologically created boundaries that automatically associate risk and mental illness. The impact of the risk agenda associated with mental illness is discussed later in this chapter.

The exposition of underlying beliefs about mental disorder was given explicit deliberation in the focus group which included the effect of prevailing beliefs in relation to the dominance of medical understanding of human behaviour. This expressed itself in the way the AMHPs described the misinterpretation of religious belief and the general medicalisation of everyday life. It was underpinned by a contention that medical explanations were dominant across society, this included the general population, mental health professionals and service users themselves. This view is consistent with writers such as Whittaker (2010) and Moncrief (2008), who posit that we have come to accept medical explanations for much of our behaviour. In this discussion, the AMHPs asserted that they are not simply objects of a medically driven ideological agenda and that they hold critical views regarding psychiatric positivist beliefs. The paradox was that they felt unable to exert enough influence to counter the wider belief systems and therefore they had to work within the parameters of this agenda to minimise harm to the individual. Although the AMHPs in the interviews did not express their critical views of mental disorder as explicitly as those in the focus group, their critical methods of using counter-intuitive approaches and scrutinising the evidence suggests that these critical views do find their way into practice. This critical approach to considering information has been identified by other writers (Osmond and Landau, 2010; MacDonald, 2010) as an important feature of professional decision-making.

The focus group findings demonstrated issues and concerns about inconsistencies in psychiatric diagnosis. There were echoes of Pilgrim's (2014) description of how the diagnosis of service users varied over time or depending on who was diagnosing them. Pilgrim's criticism of psychiatric

positivism contends that inconsistent diagnosis and differential diagnosis between different psychiatrists puts psychiatry outside methods of general medical diagnostics. The findings of the present study concur with the critical realist approach of Pilgrim (2014) in that AMHPs reflected on whether psychiatry has become part of the State's management of unintelligible behaviour that breaches normative rules. The AMHPs also referred to the belief that there is an over-reliance on medication when addressing mental health difficulties and that, often, they are only left with detention as an option due to the paucity of other options. They expressed strong views about the social causation of mental illness and the over medicalisation of mental illness, although they appeared resigned to the fact that their beliefs came secondary to medical expertise and lobbies such as the pharmaceutical industry. This may be reflective of the status of social work in its struggle with professional credibility (Schon, 1991) and from which discipline, the majority of AMHPs have historically come.

The AMHP role is no longer exclusively social workers and the evidence elsewhere would suggest that there are no significant differences between social work and non-social work AMHPs (Stone, 2018). Nevertheless, the findings from this study (comprised solely of social work AMHPs) revealed the inclusion of critical social perspectives (a crucial bedrock of social work theory and practice) used for the purpose of countering the dominance of psychiatric positivism as central to the AMHP role and this may indicate differential disciplinary perspectives. This confirms the collective finds of Hall (2016), Morriss (2015) and Bressington et al. (2011) that AMHP work closely relates to critical social work traditions and has sustained a separate identity for all professions uniquely different from their other professional roles. The paradoxical effect of this being the AMHPs have an awareness that they are operating in an ideologically hostile environment which they embrace as part of their identity and role although they have limited power to affect the outcomes they would wish to see.

As has been established, the framework of understanding that the AMHPs in this study used when approaching the question of mental disorder incorporates elements of critical approaches to psychiatric positivism. There is the belief that people experience something collectively named as mental illness or mental distress whilst at the same time there is the contention that this is not entirely biologically determined and requires contextualising. This places this group of AMHPs within a critical realist understanding of mental disorder. The material reality is that statute law sets the legal boundaries including the role of the AMHP. They are also critical of the legal/medical process and it is not a framework of their choosing, however they repeatedly describe their role and its authority being

derived from this legal framework. Therefore, their expressed resignation with regard to the degree to which they can change outcomes is intrinsically bound to their professional identity.

The research found that AMHPs use frameworks of understanding that are critical of psychiatric positivism but accepting of the reality of mental illness, their approach places them within a critical realist framework of understanding. This critical realist approach is apparent in contextualising by the AMHP of the service user's behaviour to test alternative explanations. It is also apparent in the AMHPs requirement that there is a causative nexus between the person's presentation and perceived risks.

This identifies that the AMHP continues to hold a strong affinity towards critical perspectives towards mental disorder and that there remain alternative perspectives to psychiatric positivism with the mental health professions.

## **6.5 Social Perspectives Framework**

The findings suggest that the AMHPs identify social factors they consider to be significant when considering someone's mental health. However, they do not present these as pre-determinants of detention and or actuarial indicators of risk. The reflection on social factors was multi-dimensional or multi-layered. There was an awareness that certain social factors increased the likelihood of detention and that certain groups were disproportionately detained. The misunderstanding of people's cultural beliefs and actions was something that the AMHPs believed should be guarded against. As highlighted by Hatfield (2008), there are significant social factors that increase the likelihood of detention under the MHA, these findings suggest that the AMHPs are aware of these and apply a critical approach that seeks to calibrate their assessment accordingly.

The focus of the interviewees was predominantly on the person's mental health history, current presentation and immediate social circumstances and how these impacted on the person's mental health. Social factors were primarily assessed in terms of identifying countervailing tendencies in relation to medical approaches in order to understand and contextualise the situation. Socio-economic factors were also considered, but more in terms of what support networks the person had and how social factors such as gender, race, and age had impacted on the person's mental health.

These factors were discounted as reasons in themselves for detention. Glover-Thomas (2011) also identified that social factors were considered as a way of contextualising the situation and to avoid making presumptions.

The semi-structured interviews provided insight into the factors considered during the process of undertaking an assessment while the focus group discussion offered more insight into the broader discursive and ideological facets of mental health as a field of practice. The focus group discussion would support the view that AMHPs are aware of the impact of cultural factors whilst at the same time acknowledging that their own lack of cultural awareness and lack of culturally sensitive services has a negative impact on the outcome of the MHA for some people. This issue of cultural interpretations featured strongly in relation to the possible misinterpretation of people's behaviour as a mental disorder. Participants also identified the lack of specific services to support people from BME communities exacerbated the problem by failing to provide alternatives that prevented mental health problems developing. There are strong themes in the literature on the role that culture plays in the experience of mental illness and the interpretation of people's behaviour. The way the focus group discussions developed around the issues of religious beliefs and how beliefs can be misinterpreted as signs of mental disorder, aligns with writers such as Watters (2010), who contends that the globalisation of western medical approaches to mental disorder is a factor contributing to the treatment of indigenous populations by external aid agencies whose training is based on western clinical practice. The AMHPs were not working in other cultures in other countries but they reflected on the changing demographics of their localities and the fact that they were assessing people who have different cultural backgrounds and beliefs rooted in other societies.

There was the expressed belief that institutionalised racism also plays a part in the assessment and treatment of people from non-white heritage. This was not explored in detail but the reason for high numbers of detentions of people from BME backgrounds was described as institutional racism which reflects the historical perspective on the discrimination of African Caribbean/African American people given by Kutchins and Kirk (1997) and the belief by writers such as Cohen (2016) and Ferguson (2017) that these historical relationships have become embedded in institutional and medical practice. The CQC reports (2014, 2018) and other studies, Hatfield (2008) identify the disproportionate amount of people from BME backgrounds who are compulsorily detained using MHA. This was not explicitly described as institutional racism in the study but discussion of factors around ethnicity that emerged

within the interviews demonstrated an awareness about the potential impact of racism on mental health assessment outcomes.

A strong theme in the focus group discussion was about the social causative factors that impacted on people's mental health. This was not just with regard to the person's individual circumstances it included much wider societal changing patterns of behaviour, such as misuse of illicit substances and the changing nature of communities. There was a consistent belief expressed that society has changed over the course of their lifespan and that there were now generally lower levels of social solidarity. The AMHPs described the perception that in a previous era community would have been more supportive of individuals and there would have been less of a need for the intervention of statutory services. This dovetailed with the belief that we now incorporate a wider scope of human behaviours into what we describe as mental illness. This was consistent with the belief of Ferguson (2017) that we have moved from what he describes as picket lines to worry lines and where previously people would have resolved many of the stresses and difficulties through solidarity action, they now seek diagnosis of their misery and a prescription or doctor's sickness certificate. This was echoed by one of the participants who described the day to day struggles of living within the social benefits regime and the pressures on children in schools to perform to tests and standards as a causative factor in rising numbers of those presenting with mental health difficulties. Cohen (2016) argues there is a direct causal link between the economic organisation of society and response by the state to deviance and difference. Cohen saw the medicalisation of children's behaviour by diagnosing conditions such as Attention Deficit Hyperactivity Disorder and Oppositional Conduct Disorders as a form of social control of children reacting to increased forms of control and monitoring of school life. This structural approach or critical realist perspective by the AMHPs was evident in how they make sense of their role by considering micro and macro factors in an attempt to create their own unifying theory.

For example, the AMHPs had observed changing patterns of support and welfare, which were expressed in relation to the changing role of women. It was acknowledged by the participants that their belief that previous support for women at home by other women was no longer possible (or desirable) because women no longer remained at home in the same way as they used to, acting as informal carers for their family and others. At the same time, it was recognised that because many behaviours had now become medicalised and decisions professionalised, there could be an increasing tendency towards the pathologising of behaviour. This was a theme in Kutchins and Kirk's (1997) study of the medicalisation of women's behaviour. Though somewhat dated, Kutchins and Kirk research

resonates with the views of this study's focus group participants in that psychiatry has disproportionately diagnosed women as mentally unwell and had created diagnosis for women that were potentially discriminatory in relation to their future treatment. The most well-known examples being neurosis, hysteria and various diagnoses of personality disorder. The social causation of mental ill health described by the AMHPs also had echoes of Ferguson's (2017) contention that the increasing levels of mental distress are linked to an increasing sense of atomisation and alienation in society. It further reflects the views of writers such as Watters (2010), Whittaker (2010), and Moncrief (2008) who, following on from Kutchins and Kirk (1997) argue that the dominant ideology of medical diagnosis leads increasingly to the individual pathologising of people's behaviour. This process then, as described by the AMHPs, leads to the dominance of psychiatry in dealing with behaviour that stands outside the norm or, as Pilgrim (2014) describes it, the professional diagnosis of incorrigible or unintelligible behaviour.

The specific degree to which AMHPs ensure that social perspectives were considered was outside the scope of the research. There have been questions raised in the literature by various authors Campbell (2010), Hatfield (2008), Furminger and Webber (2009), about the continued inclusion of social perspectives; following the MHA amendment in 2007 and the possible dilution of this with the inclusion of other professionals. The findings of this research would suggest that the inclusion of social perspectives of mental illness is a significant factor in the beliefs of these AMHPs.

The research identified that the AMHPs consideration of social factors was primarily an expressed belief that certain variables in the service user's life were protective or increased risk. The weighing and balancing of the presence or absence of protective factors was further evidence that the AMHPs worked outside a psychiatric positivist framework of understanding. Mental illness was viewed as a social problem more than a health problem. This practice of wisdom points to the need to strengthen personal and systemic support for service users experiencing mental health crises.

## **6.6 Risk Framework**

The focus on risk as the primary determinant of decision-making was a consistent finding of this study, presented as a framework or series of frameworks that were explicitly stated when the AMHP was deliberating options. This is reflective of the literature which suggests that the risk agenda and the associated perception of risk/dangerousness associated with mental illness is a primary driver in the decision to deprive someone of their liberty using mental health legislation (Hatfield, 2008; Pilgrim,

2014; Szmukler, 2013). Pilgrim (2014) and Szmukler & Rose (2013) however, have contested the legitimacy of the association of mental illness and risk. The way in which AMHPs construct their decisions based on perceived evidence of danger or risk and the inclusion of certain factors in this process are illustrative of how the AMHPs position themselves in the risk debate. Particularly the question of whether or not AMHPs uncritically accept that the presence of mental illness automatically brings with it associated risks.

The other important question was how risk was identified and rated, in the absence of a definition of risk or a named theoretical framework, it could be suggested that the AMHPs use arbitrary factors regarding risk, which are developed anew at each assessment. However, the factors of concern that AMHPs identified were similar across all interviewees and fell broadly within the criteria for detention under the MHA and its CoP/MHA. Risk assessment was found to be an interpretive exercise but one that is boundaried by legislation. Also, and consistent with research by Glover-Thomas (2011) was the finding that risk terminology is commonly used by practitioners, although they may not necessarily provide a precise definition of what risk is. Glover-Thomas (2011) described this as a circular explanation or the “risk is risk” paradox, in which practitioners could not define risk in the abstract but claimed to know what they were looking for.

The present study also showed that the application of the law was pre-emptive, rather than being reactive to the occurrence of harm with the AMHPs taking the view that their role was preventative. Szmukler & Rose (2013) argues that assessments of risk in mental health focus too much on false negatives rather than false positives. In other words, the number of people detained because of the risk of harm to self or others is disproportionate to the harm actually occurring within the subject group of people experiencing mental illness. The AMHPs in this study clearly stated that their estimation of risk was designed to prevent future harm, which could be viewed as defensive practice although it does need to be noted that in the case vignette, the individual is part of a group where additional risk has been identified due to substance misuse (Szmukler & Rose, 2013; Pilgrim, 2014). The clearest claim that can be made is that similar to the findings of Peay (2003), that it was the perception of future risks to the person or the possibility of risk to others that pushed the decision-makers in MHAs towards some form of compulsion, rather than leaving the situation to develop.

The AMHPs only considered risks believed to be associated with the person’s mental illness or its possible deterioration; this would be consistent with the criteria for MHA. The evidence would also

suggest that they are attempting to establish a causative nexus between the perceived mental disorder and the perceived risks which is again consistent with the requirement in the legislation. The circumstances in the vignette involved someone with psychosis with a co-existing use of illicit drugs. As mentioned previously, Pilgrim (2014) and Szmukler & Rose (2013) do concede that although psychosis in itself does not indicate increased risk of harm, coexisting substance misuse is a factor that increases the risk of harm to self or others. Although the AMHPs did not allude to their judgement in this case being based on empirical research about risk and coexisting substance misuse, it is possibly practice wisdom that led them to include this in their deliberations.

In considering risk, static risk factors such as, the person's previous diagnosis or risk history were never the sole criteria for assessing or subsequently detaining someone, although as mentioned above diagnosis could bring with it certain assumptions about how or why an assessment would progress. This is not to say that the cultural framing of mental illness being associated with risk, as described by Pilgrim (2014), was not a factor but there was strong evidence that the AMHP tries to deconstruct this narrative. If the AMHPs were relying on static background factors alone or purely empirical data, this could be described as actuarial decision-making and they would be considering actuaries in a way that is parallel to the way insurance companies consider static factors when predicting risk (Menon, 2013). Although purely static actuarial factors were not identified as a determinant in decision-making, there were consistent factors that the AMHP sought confirmation of before proceeding to a decision. These factors broadly relate to the MHA and include the presence of mental disorder, risk to self or others and the consideration of the legislation's principles.

The study found that the AMHP approach is neither actuarial (based on empirical/historical evidence) or entirely constructed from new material and concepts developed in the present. Initially information about static factors, such as the nature of an established mental illness are requested and incorporated, which sits partly within an actuarial framework as described by Menon (2013) and Szmukler & Rose (2013). This was not suggestive of a prescriptive assessment tool but the identification of symptoms and behaviour the AMHP believes may indicate mental disorder, therefore establishing the first criteria for using the MHA powers. Account was then taken of any established history of mental disorder and associated historical risks, which reflects Menon's (2013) definition of a forensic approach to risk assessment. If assumptions or decisions had been made based simply on established diagnosis and historical associated symptoms, with the expressed belief of predictability about prognosis and how a condition may progress untreated, the AMHP could be described as

assessing the situation using actuarial or forensic approaches. In practice, both of these elements are evident in addition to which contextualised information is added, which evidences that structural professional judgement, as identified by Menon (2013), is closer to the practice of the AMHPs in this study. This type of decision-making is multi-faceted, incorporating framework building and considerations of numerous fluid contextual variables throughout.

As a general rule it could be considered as problematic to proceed from an actuarial perspective as this would be discriminatory to use generalised data about risk groups to single out individuals who were part of these groups. Although an alternative view based on the arguments presented by Szmukler & Rose (2013) could argue that by considering risk from an individual professional perspective rather than basing it on what research tells us, we are disproportionately attaching risk concerns to people because they are part of a group of people identified as the mentally ill, when the empirical evidence generally identifies that this group is generally lower risk to others. To follow this line of reasoning would mean the AMHP refusing to assess people with perceived mental illness because empirical research suggests there is less risk associated with this group. Although it is also necessary to break this down to consider different forms of risk such as suicide or homicide and additional factors that may indicate increased risk such as substance misuse or recent history of violence. The important question which requires reflection is, do the AMHPs accept the risk agenda associated with mental illness uncritically or do they factor in these considerations?

The interview evidence is supportive of the findings of (Peay, 2003) and (Glover-Thomas, 2011) that the decisions that AMHPs make are not binary in the way that legal decisions are interpreted in court. They are more fluid, and often involve chaotic, complex and constantly changing situations that practitioners are faced with. In the focus group discussions, there was acknowledgement that pragmatism in identifying risk also plays a role when the AMHP decides to detain based on the absence of alternatives to detention, rather than believing detention is the most efficacious route. The AMHPs can therefore be said to be locating their decision-making within the risk agenda that dominates decisions in mental health work although they attempt to do this critically.

The research found that risk assessment begins with the AMHP using frameworks of understanding that confirm or reject the service user's behaviour/presentation as being within the scope of a formal MHHA. The AMHPs do not use prescriptive risk assessment tools based on an actuarial model, but they do have a set of risk concerns that they seek information about that are predeveloped.

The identification of risk was often with a view to pre-empting actual harm rather than addressing existing harm. However, the process of making this determination also included the deconstruction of risk narratives that automatically associated the presence of mental disorder with risk.

This finding identifies the need for AMHPs, AMHP educators to be able to support the contentions that they make about what constitutes the possibility of real risk to the individual and others.

### **6.6.1 Deconstructing Risk**

The lack of prescriptive risk assessment tools or guidelines means that the AMHP decision-making process may be most accurately described as practice wisdom or tacit knowledge obtained and maintained within a professional culture. In this culture the AMHPs share frameworks of risk concern which are deconstructed using other concepts such as cautionary tales or counter-intuitive deconstruction of frameworks. AMHPs believe they are using their professional framework of knowledge, skills and professional tools to deconstruct dominant narratives when applying the law. The similarities identified in the approach of this group of AMHPs towards the deconstruction of risk is illustrative of a practice culture that is not based on prescriptive tools but includes similar approaches/practice tools synthesised in practice. The objective of this study was to identify the factors that AMHPs consider in their decision-making, it was not an expressed intention to determine where these factors originate or how they are reinforced. However, the findings of Stone (2018) on the decision-making of social work and non-social work AMHPs, Bressington et al.'s research (2011) into AMHP training and the research of Morriss (2015) do provide insights into how the AMHP role is distinguished from the role of other mental health professionals.

Tacit knowledge and practice wisdom were also features of decision-making in the current study. This included AMHPs matching current presenting circumstances against presentations from other assessments they had been involved in and using these as a framework to understand what was going on by critically deconstructing the presenting picture. This reflects the structured professional judgement approach outlined by Menon (2013) where risk is considered in a more personalised way, in that personal history and symptoms and diagnosis are explored and then matched against the service user's current presentation. The AMHPs seemed to match the person's current presentation and diagnostic history and gave additional weighting to similarities with previous episodes when the person had been unwell. This indicates that although there are elements of *both* actuarial and forensic

decision-making by AMHPs when considering risk as outlined by Menon (2013), this was then subjected to further contextual scrutiny. The AMHPs also used their previous experience as a cautionary tale, the general message being the AMHP had seen similar situations before and failure to use the tacit knowledge and practice wisdom derived from prior experience could result in a negative outcome. The AMHPs looked to see if the behaviours were truly indicators of mental health relapse (searching for a causative nexus) and, even where they believed this to be the case, they further questioned whether risk had actually occurred when the person was previously unwell. Although this method was evident across the interviews it was never suggested that it was based on any particular theoretical method or named practice tool.

This process of using binding precedent; was also observed by Glover-Thomas (2011); practitioners believed that part of their skill set was comparing current cases with cases they had dealt with previously, using binding precedent as a way of estimating risk. Glover-Thomas (2011) describes these binding precedents as “subjective moral codes” (p. 599), which run the risk of prejudicing the decision if this was approached uncritically. In an outcome-based model, the practitioner starts from the outcome and works backwards. By deciding on an outcome and retrospectively selecting evidence, the practitioner can create a narrative allowing them to do what they think is best for the person in a given situation by weighting risk factors accordingly. It was evident in this research that the AMHPs were identifying a behaviour or concern and explaining why it might indicate risk, but then turned it on its head by presenting a counter-intuitive explanation. This process was revisited at different stages of the assessment with the AMHPs giving different weighting to the concerns of others, depending upon a number of factors, including the length of time they had known the person, their relation to the person and possible motivations and explanations for their viewpoint. This process evidenced a deeper and more complex method of scrutiny to the simple application of binding precedents and is closer to the method identified by Menon (2013) as structured professional judgement.

These methods of scrutiny incorporate themes of past, present and future similar to the findings of the Glover-Thomas (2011) study, which identified what were called dynamic, static, acute and chronic risks. Static risks being historical events and dynamic risks are those risks that change over time including substance misuse, housing and support networks. This combined approach including elements of the actuarial and forensic approaches is a dynamic process of information gathering, risk assessing, planning and reviewing which is individualised based on the patient’s story, current situation and desired outcomes. As the assessment progressed links could be seen between the

preceding picture, current identified risks, concerns and protective factors, all of which were used to try and predict the future. This dynamic constantly changed as live information was fed into the assessment process, such as perspectives from others who had more knowledge or direct contact with the person.

There was no separation or distinction that demarked the use of one particular model or another; rather, what can be said is that there was a framework or frameworks of understanding that the AMHP constructs. This appears to be underpinned by general areas of concern the AMHP considered, areas that were then populated with risk information that is historical or current. These concerns are triaged using past precedence for the AMHP or the individual. The additional time dimensions were evident across the interviews, and elements of risk consideration were present within each time dimension for example past evidence of harm to others, current harm to others and future possibility of harm. They changed in their emphasis as the assessment progressed to be less focused on themes of past and increasingly focused on themes of future. This presents as a dynamic process throughout but culminates in the ultimate test of these hypotheses in the face to face interview and process of elimination or confirmation. This is not an isolated task undertaken by the AMHP, but a collaborative process which begins with consultation with other professionals and family. It ends with consultation and collaboration with the person being assessed and can move back to consultation with other professionals and family. This is also not an abstract process of eliminating and confirming beliefs but is the creation and deliberating of options.

There were critical views of risk including the belief that determining risk can be medically driven and attached to diagnosis, rather than being associated with the individual or the situation. It was expressly stated that being different, acting strangely or upsetting others was not in itself a reason for assessment or detention and that the possibility of some kind of harm occurring was the important consideration. A process of complex decision-making that built on historical and current concerns was evident, as the AMHP built a picture using various pieces of information presented to them and requested by them. The evidence was then tested against the AMHP's framework of concern. This is similar to the approach described by Glover-Thomas (2011), in which the practitioner uses a risk recipe model choosing various ingredients, primarily the patient's clinical history, with the additional inclusion of current clinical factors and current social factors. As discussed before, part of this process is the matching of the presenting circumstances with previous experiences as a predictor of possible outcomes or as Szumukler & Rose (2013) describes it, bringing the future into the present so the AMHP

can approximate the possibility of future harm. In Peay's (2003) findings, the decision-makers appeared to use a mix and match approach in which they cherry picked factors they considered relevant and engaged in post hoc rationalisations to justify their decisions. The AMHPs in this study were clearly not using a prescriptive risk assessment tool and therefore the elements they considered and how they considered them were guided by professional judgement. They were working to a risk agenda whilst at the same time attempting to deconstruct risk concerns as presented by others. Although the elements considered were varied, there was no evidence that these were random, or cherry picked to confirm a predetermined conclusion.

This study therefore suggests that the AMHPs considerations may be dominated by the risk agenda, but they are engaged with this agenda critically. There was strong evidence in these deliberations of the methodological approach similar to that proposed by Osmo and Landau's research (2010) to try and ensure more objective decision-making. This included an awareness of the factors that affected their decision-making and being willing to open their decision-making to scrutiny, in the interviews this is presented as both internal and external reflection, similar to practice where the AMHP shares their views with the person being assessed, family and other professionals. The other element that needs to be considered is that AMHPs describe making decisions in the moment. As Gray and Gibbons (2007) described, decision-making is an art practiced in the social world, therefore responses to questions need to be immediate and access to others who can assist with external reflection is often limited. However, this does not exclude the impact of critical reflective or reflexive practice having an ongoing impact on the practice wisdom of the AMHP and future situations they encounter.

The findings confirmed that AMHPs did not use prescriptive risk assessment tools although they share similarities with other AMHPs in how they construct risk frameworks of understanding and deconstruct these frameworks. The tools that were identifiable were the use of cautionary tales, counter intuitive interrogation and critical social perspectives. The AMHPs also wanted to ensure there was a causative nexus between the person's identified mental disorder and risk concerns.

The AMHPs tested the quality of the information by several different methods contextualising the information based on who was presenting the information, their relationship to the service user and how the information matched with other information.

AMHPs considerations work across all three time dimensions and there is a dialectic relationship in how they interact. Present concerns are matched against past presentations, current concerns are

used to predict future harms and the possibility of future harms are used to plan current interventions.

The similarities in the approaches that the AMHPs took in constructing and deconstructing risk concerns suggest that they are not cherry-picking facts to justify predetermined outcomes. The consistency is based on tacit knowledge, professional wisdom and legal frameworks.

These findings lay the foundation for further research into the efficacy of these methods of deconstructing risk narratives and the degree to which they can claim to support sound decision making.

## 6.7 Legal Framework

The study showed that the AMHPs consider decisions within a series of frameworks which are distinctive in some ways, such as approaches to understanding mental illness and the risk agenda. There is also overlap as they are all being considered with the framework of the legislation. The legal framework is not therefore a framework with a single facet, but reflects the various aspects of the legislation, its code of practice and the AMHPs interpretation of this guidance. Part of this interpretation includes the ongoing contemplation of the concept of mental disorder.

The criteria for detention under the MHA include the requirement that the person must be suffering from a mental disorder of a nature or degree, as laid out in part two of the MHA. The mental disorder must be established by a suitably qualified doctor with specialism in mental health and any decision to detain must be in the interests of the person's health and safety or with a view to the protection of others (Jones, 2019). The AMHPs were aware of their specific role, working within a legal framework and regarded mental health legislation as a necessary safeguard to protect against arbitrary detention. For example, they openly questioned whether the request being made fitted within the requirements of a MHA rather than a generic assessment of the person's mental health. This finding appears to contradict that of Peay (2003), who states there is often little explicit reference to the law/case law in AMHP practice or, the observations of Glover-Thomas (2011) that objective legal thresholds are not used. In the current study these legal concepts were considered even though they were not always explicitly stated. Elements of the law that were explicit include the *least restrictive and maximising independence principle*. Other principles, case law and legal concepts such as, 'balance of probability'

were implicit in the language of consideration but not overtly stated. The legal paperwork in the form of the application does not refer to these principles specifically which would possibly explain why the AMHPs did not give them greater emphasis.

### **6.7.1 Considering Less Restrictive Alternatives**

The *least restrictive and maximising independence principle* was the most explicitly stated in the AMHP's considerations in all the phases of decision-making, although there was implicit evidence of the inclusion of all the principles at various times. Examples of this include the *purpose and effectiveness principle* when considering the reason or efficacy of a decision to detain someone or, the *empowerment and involvement principle* when gaining the person's view of the situation. A possible reason for the AMHPs being explicit about the *least restrictive and maximising independence principle* of the MHA is that this is the only principle that is explicitly stated as part of the AMHP's role in the CoP (2015). As this is an explicitly stated principle, it is of interest how the AMHP negotiates this, particularly in relation to admissions to hospital (detention).

The belief that applications for admission by the AMHP were made because of a lack of less restrictive alternatives was a strong theme in the focus group. The AMHPs described the difficulty in securing less restrictive alternatives to admission as primarily arising from a lack of viable alternatives. The difficulty was described as a macro issue, which, in an era of austerity resulted in limited physical resources and services being unable to match the level of demand. This is reflective of the writing of Ferguson (2017) who identifies austerity as a driving force for reduced community alternatives to detention. There was less of a focus on the micro issue described by Hall (2017) who identified difficult negotiations between different professional cultures about finite resources as a possible explanation for these resources not being available.

The AMHPs described the pressure to detain someone they sometimes feel, arising from the expectations of other professionals or the person's family. Although this was not cited as the most significant factor in the decision-making process, there was an acknowledgement that not detaining could have negative consequences for themselves, should harm occur afterwards, which partly confirms the findings of Glover-Thomas (2011), that practitioners acknowledged how the perception of others affected the decision-making, particularly regarding the scope to take positive risks. There

was significant emphasis on the benefits of taking positive risks, in situations where the practitioner acknowledges that harm is occurring but believes this is likely to be short term. In the longer term they perceive that a detention would do more harm to the person and might therefore be disproportionate. This is a recognition of the concerns of Campbell & Davidson (2017) regarding the iatrogenic effects of detention; but even though they hold this belief they still feel pressured when this perception of managing risk is not shared by others. Participants talked openly about the consequences of their decisions being perceived as leading to negative consequences for the service user or others and how this could negatively reflect on them. They acknowledged that this would sometimes lead them to making risk averse decisions because they felt they would be blamed by others, including their own organisations. The subsequent decision to detain based on this pressure from others is reflective of the shifting of responsibility or roll over described by Vicary et al (2019).

The perception that there may be negative consequences for the practitioner should there be a negative outcome was less evident in the interviews. The findings suggested that sometimes the AMHPs, even with the presence of risk, considered that doing nothing was less harmful to the patient. These decisions not to detain could be taken in opposition to the view of family, the service user or other professionals based on the belief that not detaining the person was a positive decision. Risk aversion arising from possible negative consequences for the practitioner has been identified in other areas of practice (Kemshall & Pritchard, 1997; O'Connell, 2011) and is cited as a contributory factor in oppressive decision-making. There was very little evidence from the interviews of decision-making based on an aversion to risk because the AMHP believed they would experience criticism should harm subsequently occur. The primary focus of decision-making remained the potential of harm to the person and those around him, including family and friends.

That the subjective or emotive elements were more apparent in the focus group was possibly due to this choice of research method which meant that participants could collectively and safely explore the issues that they find most challenging. Furthermore, because they were not being expected to discuss processes (as was required of interviewees), they could more freely explore their role in relation to their underlying beliefs and aspirations. The focus group discussion also focused more on the question of assessing people with personality disorders, where the vignette used for interviews focused on someone with a history of psychosis. It may be that the AMHPs are more comfortable with making decisions about people with a particular set of symptoms or diagnosis. This could be reflective of the underlying beliefs about what is considered to be a true mental illness and what constitutes a separate

category of behavioural disorders. These debates have been identified (Kutchins & Kirk, 2003; Moncrief, 2008; Watters, 2010; Whittaker, 2002) as running through the conceptual differences of those seeking to make sense of mental illness or mental disorder. It is particularly reflective of the way Kutchins & Kirk (2003) describe the adjustment of diagnostic categories in the interests of those who have the power to do this.

### **6.7.2 Capacity and Insight; Medical meets Legal**

The MHA allows for the compulsory detention of a patient for a mental disorder if they are unable or unwilling to consent to their admission or treatment. The CoP/MHA guides the decision-makers on the necessity of assessing capacity when considering informal and the use of MCA principles in making this determination. The assessment of capacity is decision specific, in other words the AMHP is not assessing global capacity but capacity in relation to a specific question. In this scenario, it is the person's capacity to consent to informal admission using MCA principles, within the context of another legal process, the MHA.

In addition to and sometimes as part of the functional legal test of capacity, the concept of insight was also introduced by the AMHP's. The issue of insight and capacity is an area of decision-making where the concepts of diagnosis, autonomy and the law could be identified as interfacing in an overt way. This presents in the findings when a decision about detention or the viability of *least restrictive* alternatives needs to be considered. Here the overlapping issues of medical diagnosis, associated risk and *least restrictive* options were explicitly considered and spoken aloud. The *empowerment and involvement principle* of the MHA, which encourages the participation of the person being assessed, was not named but the elements contained in this principle could be identified. The consideration of these two principles could be identified in the deliberations the AMHP undertook whilst trying to balance the autonomy of the individual with the need to manage perceived risks. There was also evidence that the AMHPs were working to the legal concept of the balance of probability when weighing up the evidence they had gathered but again this concept was not explicitly named.

The concept of insight is regularly referred to in the interviews as a risk factor when the person holds beliefs that may pose a risk to self or others. Insight is also regularly used to confirm or eliminate the possibility of the least restrictive alternative, even though the term "insight" does not appear in the MHA or the CoP/MHA and has therefore no legal status in law, other than as diagnostic criteria by the

doctor. The unpicking of the concepts of insight and capacity is clearly an important element of how the AMHP negotiates the process of deciding about outcomes of an assessment. The evidence from the interviews identified that the concepts of insight and capacity were mostly treated as separate issues, although sometimes the two concepts were fused or used interchangeably.

Peay (2003) predicted that the 2007 amendment to the MHA would probably lead to MHAAs in the future that were entirely capacity based. Although this did not happen, the findings of the current study showed that the language and principles of the MCA were being applied in an explicit way in considering and eliminating less restrictive options. This was stated by some of the AMHPs as a legal requirement following the Supreme Court ruling of 2014, commonly referred to as 'Cheshire West', about admission to hospital. The assessment of capacity when deciding about informal admission and the use of a structured mental capacity assessment when doing so is consistent with the CoP/MHA.

The explanation for the continued use of the concept of insight in these considerations is possibly because the MHA is not an entirely capacity based piece of legislation and continues to allow for compulsory measures to be used for those assessed as having capacity. Therefore, not all decisions made by AMHPs require explicit reference to the assessment of a person's functional capacity and AMHPs therefore can use a quasi-legal concept even though it sits outside the formal legal language of the MCA and MHA. The use of the concept of insight as a replacement for a capacity test would not be supported legally if it was used as a substitute for the determination of capacity to consent to informal admission. However, if insight is considered as the nature or degree of a disorder, it can be argued that lacking insight could be considered as a component of the diagnostic test in determining lack of capacity and/or the manifestation of a disorder which impacted on the person's ability to understand, retain, weigh or communicate a decision (establishing the causative nexus). In other words, if the AMHP states lack of insight arising from a mental disorder as a factor impacting on the person's ability to decide, this would potentially sit within an established process of legal decision-making under the MCA. Also, if the doctor stated that lack of insight was a diagnostic feature or manifestation of a condition that produced risk, this would sit within the concepts of nature or degree established under MHA. However, if the concept of insight was used to replace the functional assessment of capacity, this would sit outside of the legislation.

This degree of complexity and explicit working out of concepts and legal frameworks was not always overt in the interviews but various elements of these concepts were apparent across them all. The question of capacity to consent being assessed and the role of insight in this process, was not in the original aims of this research but these findings can be explored in relation to the findings of other studies. In the current study, the AMHPs did not conflate the issue of capacity and best interest dependent on the level of perceived risk, as was reported in the findings of MacDonald (2010). While there *was* conflation about the concepts of capacity and insight, capacity *was not* conflated with risk or best interest. The concept of insight was used as a risk assessment measure, while capacity was assessed as a measure of understanding the person has about their perceived mental illness by others and explicitly to determine the legality of the decision to be made regarding possible inpatient admission.

It is difficult to separate how the two concepts are interpreted in practice and this is an area that warrants further exploration. MacDonald's contention was that social workers understood the separation of assessing capacity from making best interest decisions in theory but in practice the two tended to be conflated (MacDonald, 2010), although it has to be noted that this was a finding regarding the understanding and use of MCA by social workers in everyday practice and not specifically decisions by AMHPs. The MHA does not, however, require the person to lack capacity before action is taken; therefore, the assessment of capacity takes on a unique role in the context of an assessment. An understanding of the difference between MCA and MHA regarding this particular question was only expressed explicitly by a small number of AMHPs. However, the application of knowledge in practice evidenced that AMHPs adhered with the legal guidance in the CoP/MHA that detention could still take place under the MHA of a consenting capacitous person, if the AMHP believed that there was disguised compliance or evidence of fluctuating capacity to consent.

MacDonald (2010) identified that sometimes this ability to understand was linked to the level of perceived risk to the individual arising from the decision. In other words, the greater the risk, the harder the service user had to work to convince the professional they had capacity (MacDonald, 2010). Peay (2003) found that decision-making tended to be based on best interest and not necessarily on legal concepts such as autonomy. It is important to point out that Peay's findings predate the MCA and that a nuanced examination of elements of the MCA / MHA needs to take into consideration certain details. Firstly, a capacity assessment about the person taking risk decisions may include a

greater level of understanding with regard to the decision about risk, dependent on the complexity of the decision to be made. Secondly, the MHA is not an entirely capacity based piece of legislation, therefore practice would not necessarily adhere to the concepts of autonomy implied within the right to make unwise decisions in the MCA. Crucially, and in some ways most importantly, the MCA is based on the best interest of a person who has been assessed as lacking capacity and there is no provision for considering the protection of others within current mental capacity legislation.

To understand these findings, we need to consider the AMHP's role in considering two pieces of separate legislation and the complex relationship between the two in the context of a single decision-making process. It is no surprise that, as there is no fusion in law, there is no fusion in practice. In many ways the variable responses to the issue of capacity and insight of the AMHPs reflect the room for interpretation caused by an absence of specific guidance and the impact of case law on one piece of legislation, which may or may not impact on the processes of the other. The courts act as independent public authorities which retain the right, after due consideration, to interpret the law according to various factors including the facts of the particular case. The higher court decisions are made in relatively sterile courtrooms where the judge receives considered submissions from trained barristers, where the judge can access independent legal guidance and then take their own time (there are usually three judges in supreme court cases) to consider the judgement and outcome. The unique position of AMHPs as independent public authorities also allows for the interpretation of the law within certain boundaries. These decisions in the case of community assessments are taken in people's living rooms and kitchens, in often highly emotionally charged circumstances over the course of a couple of hours. Therefore, there is an almost inevitable variance with the written judgements of the higher courts.

The evidence from this research suggests that all the AMHP decisions were taken within the boundaries set by the legal framework. The criteria for detention and the least restrictive principle were the elements that were most often expressed explicitly.

The AMHPs are most explicit about the consideration of the mental disorder, nature and or degree criteria and the least restrictive principle of the MHA. The other principles of the MHA are generally expressed implicitly in the AMHPs considerations.

The consideration of the least restrictive principle takes place in the context of other principles such as participation principles and other legislative concepts of the MCA. The AMHP uses a mixture of diagnostic concepts such as insight alongside MCA legal concepts of functional understanding to weigh the viability of less restrictive alternatives.

The least restrictive principle was expressed as an essential consideration, it was acknowledged by the AMHPs that its implementation was hampered by resource considerations and pressure brought to bear by others.

The AMHPs adherence to a legal framework points to the primacy of legislation and the role of the legislators in setting the boundaries for professional decision making. It also highlights that where the law is unclear or open to interpretation with concepts such as insight and capacity, professionals will vary in how they apply concepts that are not clearly defined.

## **6.8 The Identity and Role of the AMHP**

The narratives explored above concern concepts of mental illness, the risk agenda and interpretation of the law. In this section I explore in more detail, the identity and role of the AMHP and how these shape and impact upon their decision-making. This narrative pertains to the more personal elements relating to the AMHPs perceived role in relation to others, the application of social perspectives and the personal conflict the AMHP experiences being the person at the centre of these processes.

### **6.8.1 Inter-professional Frameworks**

The significance of inter-professional frameworks or how the AMHPs see themselves in relation to other professionals was described in both the interviews and the focus group. External influences on the AMHP came from several sources and included differences in perception of risk. This could be a difference of opinion with practitioners in CMHTs about the necessity of a MHAA, including the expectation of what other practitioners should have done before making a request, such as

considering less restrictive alternatives to assessment or detention and proactive engagement by other parts of the mental health service.

The AMHPs perceived that there were occasions when the request for a MHAA was driven by other agencies or professionals not understanding the law, being too quick to consider detention or not considering the impact that being deprived of liberty has on the service user. This reflects the findings of Vicary et al (2019) who reported that other professionals (particularly doctors) were perceived as shifting the responsibility onto the AMHP. In the current study, AMHPs described the shifting of “the dirty work” (Morriss, 2015) at an even earlier stage by other professionals who were perceived as moving too quickly to an assessment without offering preventative interventions which would not require the involvement of an AMHP. This conflict was thought to be due to other agencies either not understanding the process of a MHAA or their agency’s role in the process. AMHPs described the tensions and difficulties they experience arising from trying to liaise and coordinate with a range with other organisations including the police, ambulance, HBT or the people responsible for identifying inpatient psychiatric beds. The way the AMHPs illustrated the point regarding these issues was a finding in itself in the focus group. Similar experiences and beliefs were exchanged, shared and reinforced in the process of discussion, resonating with Morriss’ (2015) telling of ‘atrocious stories’ and the co-narration of these stories as a way of binding the group identity.

The AMHPs expressed a generalised belief that it was doctors who were more risk averse and being medically focused on the person’s symptoms, minimised the person’s social circumstances. One example of this being the belief that doctors were more focused on non-compliance with medication as the cause of relapse rather than other social factors. The perception of the AMHPs in this study was significantly different in their approach to other professionals concurs with the findings of Morriss (2015) and was evident in the way they described how they interrogated the perceptions of other professionals and their descriptions of inter-professional disagreements.

For example, AMHPs felt that doctors sometimes pre-empted an outcome before the assessment had taken place or tried to force a decision that was not the least restrictive. Differences of opinion with doctors, particularly where the question of personality disorder diagnosis is present again highlighted the different perspectives. This difference of opinion about the purpose and efficacy of admission is raised in the literature (Campbell, 2010; Hatfield, 2008; Furminger and Webber, 2009) and

demonstrates the unique social perspective brought to the assessment process by ASWs and latterly AMHPs. However, this process was not binary and the AMHPs did not commit themselves to a single perspective. Differences of opinion with doctors about risk was also described as being two-way; sometimes AMHPs believe there is a risk and doctors do not see the person as meeting criteria for detention. There are also differences of opinion between the two doctors, or the AMHP and one of the doctors concur but the second doctor disagrees. This points to the complex negotiations that take place during an assessment, negotiations that are multi-faceted and include diverse and shifting perspectives between the participants. This was discussed by Peay (2003), who found a difference in the decision-making and outcome when doctors and ASWs were asked to consider the same vignettes together rather than individually.

The interviews undertaken as part of this research would suggest that, in the context of MHAAs, AMHPs describe practice where there is significant common ground with doctors when they are making decisions. However, there was a much clearer divergence with the views of doctors in the focus group. Various researchers have identified these co-existing separate and unified perspectives between AMHPs and other mental health professionals. Hall (2017) identifies how those in the ASW/AMHP role have developed an identity and perspective different from other mental health professionals while Stone (2018) suggests that the decision-making of AMHPs is indistinguishable regardless of professional background. The research of Morriss (2015) gives an insight into how separate identities of AMHPs are maintained and Bressington et al. (2011) sheds light on the process by which social workers and other healthcare professionals synthesise their practice during AMHP training. The focus group evidence suggests there is a strong commitment to social perspectives amongst AMHPs which is tempered in practice.

Dwyer (2010) observed that, rather than meeting high ideals or applying good authority, much of AMHP practice was about mundane practicalities and containing risk and distress within a complex and pressured process. Gregor (2010) observed that, despite AMHPs feeling they brought an important perspective to the role, they felt they were making decisions within limited time constraints with limited information and less than adequate resources. The findings of this study reveal that AMHPs do perceive differences of opinion at times in practice between themselves and other professionals about whether the circumstances warranted an application for detention, partly confirming the findings of Hall (2017) and Morriss (2015). The study also found that even when

differences were apparent the AMHPs did not necessarily believe that differences of opinion were problematic and that the process was a joint process of assessment, decision-making and risk sharing.

The fact that the AMHP seeks to include doctors who know the person in the interview, with the belief that they bring a unique perspective either as psychiatrist who knows the person's mental health history or a GP who has previous knowledge of the person, is an acknowledgement that other professionals are able to bring an additional unique critical perspective. The AMHPs stated that this person would be able to present an alternative view of the person's history that could possibly help to contextualise their behaviour or current presentation. This inclusion is partly a legal expectation but also an acknowledgement on the part of the AMHP that there are others (including doctors) who are better able to give context. These different findings would suggest a fluid tension between the AMHP's perception of their role and its application alongside other practitioners, however, an appreciation of these differences is a way of ensuring a more consistent approach to decision-making (Peay, 2003). The decision whether or not to detain someone under the MHA is considered collectively, but the AMHP role is unique in that they have the final decision about an application and more importantly, they draw into the process all the perspectives that guide this consideration.

The AMHPs in this research expressed the belief that they do have a unique professional perspective that they value, including the legal authority to act independently of other professionals. They acknowledged that other professionals also hold unique perspectives which is something they seek to integrate into their decision making.

This approach the AMHP takes, that their role maybe different but they have no exclusive pre-determined privileged knowledge and nor is their knowledge inferior to the medical profession, identifies them as part of an essential part of the checks and balances of medical/legal decision making,

### **6.8.2 Alienation and the AMHP Role**

Many of the elements described in the literature about feeling personally conflicted were reflected in the findings of this study. Internal conflicts surfaced: examples include assessing people from service user groups the AMHP is not familiar with; trying to convince others of a course of action they are

unsure of themselves or, reflecting after the event and being ambivalent about whether their decision to detain someone or not had been the correct course of action.

The intrapersonal nature of decision-making runs through much of the literature; Schon (1991) describes the process of problem setting as requiring a certain kind of self-conscious work by the individual professional. This process of framing (Strachan & Tallant, 1995; Russo & Shoemaker, 1992; O'Sullivan, 2011), although boundaried by statutory legislation, also contains strong elements of personal style and preference (MacDonald, 2010; Menon, 2013; Peay, 2003). This personal element of AMHP decision-making is inevitably bound with their sense of self and the affirmation that arises from being able to practice in an ethically and efficacious manner (Osimo and Landau, 2010). The contradictions that AMHPs experience in practice means the role is often not experienced in the way they would like it to be (Gregor, 2010; Dwyer, 2012). This can sometimes develop into potentially toxic relationships if the AMHP is unable to extricate the professional from the personal self (Watts & Morgan, 1994; Whittle, 1997).

The AMHP's role as a unique legal safeguard against arbitrary detention was clearly evident as was the critical role of the AMHP in relation to the dominant discourse of psychiatric positivism. These liberating or anti-oppressive roles of the AMHP were highly valued and regarded as important. However, there was a much more uncomfortable discussion about the assessment and possible detention of one group of service users, those diagnosed as having personality disorders. In a number of ways, the considerations with this particular service user group stood in contrast to those valued roles and beliefs expressed in the interviews. There appears to be a general frustration that this group of patients appeared to actively seek a psychiatric admission, at the same time, exasperation that no one knows why this paradoxical phenomenon has occurred or what an alternative approach would be. The participants sometimes approached this subject with cynical humour and the discussion at times bordered on what could be perceived to be a disparaging view of the behaviour of this service user group. Morriss (2015) identified a similar phenomenon and described how groups of AMHPs will on occasions adopt 'gallows' humour as a way of expressing their joint anxieties about working with particularly difficult situations.

People who are diagnosed as having a personality disorder are recognised by various writers as the group which is historically excluded from mental health services and the group whose presentation is

difficult to fit into the traditional view of psychiatric positivism. Watts & Morgan (1994) and Whittle (1997), along with Pilgrim (2015), provide a number of explanations as to how this can lead to a situation as described in the focus group, in which the AMHP feels in conflict or appears alienated from the person they are trying to help. The findings of Watts and Morgan (1994) and Whittle (1997) regarding the theory of Malignant Alienation are helpful here in making sense of why the AMHPs felt alienated from the service users they were seeking to support, because they felt pressured or manipulated into making a decision which they believed was not the most efficacious for the individual despite the individual's own protestations. Although focus group participants did not synthesise their thoughts into a coherent theoretical formulation, all the elements of malignant alienation theory were present in the discussion; personality traits were understood as often being created by traumatic experiences, traditional medical models of illness were viewed as unhelpful as indeed, were traditional methods of treatment. Although the AMHPs expressed an empathy toward the plight of these individuals, the overarching views indicated feelings of frustration and a sense of shared powerlessness themselves.

The most emotionally charged of the research evidence gathered was in the focus group discussion about these particular admissions which the AMHPs perceived were being driven by service users themselves. This created a considerable amount of debate and shifting opinions. The group of service users identified as the ones who the AMHPs believed sought to bring about their own admissions were people generally with a diagnosis of Emotionally Unstable Personality Disorder. The findings partially contradict the belief by Coffey et al. (2017) that the service user's own assessment of risk is not considered, the expressed belief here is that the power lies with the service user rather than the professional. The description by the AMHPs in the focus group of some assessments, would suggest that the service users in certain circumstances direct the decision-making by intentionally escalating the risk concerns, the AMHPs describe feeling pressured into making a decision to detain when they do not truly believe that this is the correct course of action. Practitioners can feel frustrated and even angry when they believe they are being manipulated or their power is being usurped. This was implied in the way that the service user group was identified as a homogenous group rather than individuals, even so far as being negatively labelled as a "gang" on some occasions. Other participants offered a more empathic understanding of the service user's traumatic experience and history and insightfully identified that service users have a common experience of shared powerlessness, being unable to secure less restrictive support outside of hospital. These contradictory states or emotions in the process of decision-making by AMHPs are again reflective of the literature (Gregor, 2010; Dwyer,

2012; Morriss, 2015) in the way that the practicalities of arranging assessment, the desire for a positive outcome, the frustration at limited decision-making potentials and personal emotional strains can result in contradictory beliefs and expressed emotions.

This divided view concurs with other studies on how different mental disorders are viewed by society and mental health professionals. Scull (2015), Kirk & Kutchins (1997) and Moncrieff (2008) write about the historic difficulties in accurately diagnosing mental disorders and separation of what are considered to be true mental illnesses from those considered to be behavioural disorders. Pilgrim (2014) uses the phrase incorrigible behaviour to describe personality disorder and unintelligible behaviour to describe psychosis. In other words, we view one group as mentally ill, because they behave in ways which evidence that the mind is not functioning appropriately and is beyond the control of the person. The other group are considered to be more in control of what they are doing regardless of the distress they exhibit. This may explain why the AMHPs feel greater empathy towards one group of service users over the other; either because they do not consider one group to be mentally unwell or because that particular group does not easily fit into concepts of illness and recovery.

This also expressed itself in the way previous diagnosis impacted on the assessment. The difference was that, with psychosis, there was a tendency to see the previous diagnoses of a psychotic mental disorder as significant in the decision to assess or detain, whereas there was a reticence about assessing for admission, those with a diagnosis of personality disorder. This adds another dimension to the findings of Glover-Thomas (2011) and Peay (2003) on the significance of previous diagnosis in the decision to re-engage someone with services. The previous diagnosis of a psychotic illness had been considered a significant factor in moving towards assessment in the vignette interviews but the diagnosis of personality disorder appeared to have a paradoxical effect in that the AMHPs were almost reluctant to want to engage with this group.

The theory of malignant alienation aligns with Pilgrim's (2014) critical realist approach to psychiatric positivism. The behaviours of this client group (personality disordered) are described by Pilgrim as incorrigible, as they persistently present with behaviours that are viewed as unacceptable to those holding consensus of opinion. In addition to this, Pilgrim describes the medical diagnosis of these behaviours as an epistemological fallacy because they are theorised as illness in a medical way.

Psychiatric positivism holds out the possibility of treatment/cure in the discourse of illness which then presents the possibility of recovery/cure. Watts and Morgan (1994) and Whittle (1997) identify this unrealistic expectation on the part of the mental health professional as a causal factor in their alienation from the service user, as they perceive the patient's refusal to recover as a rejection of the professional help they are providing.

It was clear that AMHPs sometimes make risk averse decisions to detain because they feel they have no alternative, either because there are no other resources available or the service user pushes them into a decision to detain through acts of self-harm. The AMHPs believed that risky behaviour is not always carried out with the intent to inflict serious self-harm, to end life or, to harm others but the behaviour i.e. walking on a motorway or self-poisoning may inadvertently cause disproportionate harm through miscalculation. If the person is presenting with significant risky behaviour, the AMHP is often left with limited options and feel they may be negatively judged if their decision is not to detain someone in these circumstances, regardless of whether this was in their best interests. This echoes points made by Warner et al. (2017) and Ramon (2005) in that professionals felt they would be held personally responsible if they did not intervene and harm occurred at a later point. The AMHPs expressed the belief that the nuanced nature of this harm would not be recognised by those judging their actions.

It is significant that some of the AMHPs recognise that the behaviour of some service users in some ways mirrors their own. The service users are aware of the criteria for admission and they negotiate with others to secure an admission to hospital. There is also a recognition that, just like themselves, this service user group lacks the resources that could make an admission to hospital unnecessary. The AMHPs talk about community resources that have been available in the past or in other localities which have previously provided alternatives to admission or detention. This again reflects the findings of Gregor (2010), Dwyer (2012) and Morriss (2015) in that, despite sensing that they are unable to practice in a way that is desirable, they see that part of the uniqueness of their role is to bring a deeper understanding of the situation to the table, this understanding in many ways can compound their alienation.

It is important to note that the AMHPs did not only express frustration with the service user, they also expressed cynicism towards underlying belief systems regarding mental disorder and how this was

driving a way of working that is unhelpful for the person. This was apparent in their critique of medical models of mental illness and social perspectives on why people experience these problems and in discussion of the legal and policy framework they work within. This framework is partially legal, partially social but participants perceive that it is dominated ideologically by medicalised approaches which they are institutionally required to accept. They are therefore subject to the same expectations of recovery and disappointments experienced by these service users, which they identify as being caused by working within a medicalised paradigm. There was evidence that AMHPs become frustrated with the repeated presentation by the service users seeking help and that their frustration is partly framed by the person's resistance to change or becoming well. The writing of Watts & Morgan (1994) and Whittle (1997) are consistent with the argument of Pilgrim (2014), in that there is a contradiction between the belief that mental disorder is an illness with predictable prognosis/treatment and the real experience of those they are trying to help.

The alienation caused by not being able to work in therapeutic ways and feeling like agents of social regulation was described by Ramon (2005). It also reflects what Osmo and Landau (2010) described as a gap between what is technically possible and morally desirable. The belief of the AMHP is that there should be a more therapeutic way of supporting the person with their distress and an awareness of what Pilgrim (2014) describes as the iatrogenic or negative effects of detaining someone. However, the AMHP at times feels that detaining someone in a psychiatric hospital is the only option left available to them. This is further compounded by the risk agenda as described by Glover-Thomas (2011), who believes that the key driver of the 2007 amendment to the MHA is the question of the risk posed by the patient primarily to other people. Glover-Thomas cites public anxieties and the risk agenda that dominated the period of reform as a key determinant for this. The participants in this study held the belief that external pressures, such as public opinion and organisational cultures of risk aversion, do impact on the decisions they are required to make. The desire to keep the person safe or adhere to the concerns of others about risk management, while at the same time believing that the process of detention and treatment has no real efficacy, appears to further compound the AMHPs frustration and concerns.

This element of emotional labour embedded in the assessment of risk is documented by Gregor (2010) and Dwyer (2012). This is described as a multiplicity of tasks involving the constant negotiation with professionals, carers and patients, whilst considering competing risks and rights within a resource constrained environment. As Hall (2017) describes, the AMHP has no direct access to resources, only

the right to negotiate with others for those resources. The AMHPs in this research reflected all these factors and beliefs when describing the pressure they experience from service users who appear to want to be detained in hospital and families who demand that something is done. They describe feeling that their knowledge base is secondary to the professional opinion of others and that, despite all the pressures outside their control, they would be judged if the outcome was unacceptable to others. This dilemma for the AMHP is what Osmo and Landau (2010) describes as the gap between what is technically possible and what is morally desirable.

This also reflects the description by Morriss (2015) as AMHP work as being considered dirty work. The AMHPs express an awareness of how others view them as doing the dirty work of mental health when all else appears to have failed and they openly express their own doubts about the efficacy of psychiatric detention. The classic theory of Marxist alienation is also worthy of consideration here as explained by Ferguson (2017), the three elements of alienation in modern society are the workers' separation from what is produced or having the power to control priorities. The second element of this is a lack of control of the work process or how things are done. The third element is a separation of productive relationships with the co-workers because of competition. This ideological dissonance combined with a lack of control over resources may also help to explain the expressed alienation AMHPs can feel towards this particular element of the work process.

The research found that AMHPs expressed feelings of alienation relating to their role primarily based on the limited decisions they can make due to the lack of resources available to be able to implement other support plans. This alienation was also reflected in the AMHPs lack of control over the admission process including unavailability of inpatient beds and reluctance or refusal from other services to assist the management of compulsory admission. The AMHPs identified subjective factors such as the risk agenda that further increased their feeling of lack of control over the process when they felt unduly pressured to detain someone by the person's family or other professionals. The AMHPs expressed this as a paradoxical concern when undertaking MHAs on a person with a diagnosis of a personality disorder. The AMHPs expressed the belief that an admission was generally unhelpful for these individuals but the service users themselves held the power in attaining their own admission. The classic theory of alienation was identified in helping to explain the overall experience of AMHPs and the theory of malignant alienation was found to be applicable to AMHPs when assessing particular service user groups.

This research has added to the growing body of knowledge about this subjective and less visible element of AMHP decision making which although undertaken within statutory frameworks is carried out by human participants in real social situations.

## **6.9 Conclusions**

The findings of this research confirmed that AMHPs, like many other professional decision-makers, adopt frameworks of understanding when considering MHAAs. In other words, the AMHP does not approach the situation with a blank slate or with no presumptions about what may be happening or how they should proceed. There is evidence that the primary frameworks approximate to the legal requirements and principles of the MHA, and even though AMHPs do not always explicitly state this when describing their considerations, they test information received against a consistent set of factors deriving from the MHA criteria for detention or the CoP/MHA.

The dominant theme within the framework of the law is that of risk and the management of risk which aligns with the ideological and organisational risk agenda prevalent within British society. The AMHPs describe similar risk factors that would lead them to making decisions or discounting options and though they did not refer to risk factors based on statistical studies, there was a consistency to the range of factors that they wanted information about before deciding. The findings show the development and use of similar frameworks of understanding, including the use of previous cases as templates to make sense and build a picture of the situation. These case scenarios could be used as a binding precedent or a cautionary tale. The use of a counter-intuitive deconstruction of the narrative being presented was also a tool that the AMHP used in assessment while perceptions and reflective practice enabled critique of psychiatric positivism at the macro level. The fundamental question of the nature of mental illness was evident particularly in the sense of unease AMHPs expressed about their role which they perceived as at times, reinforcing a system of beliefs that they were deeply uncomfortable with. The AMHP adopts a critical realist perspective in acknowledging the existence of mental distress as a real experience they seek to understand and make sense of even in the midst of their reflections on the social construction of mental illness.

This was not a comparative study but the perception AMHPs hold of themselves is that their perspectives are distinctive from the other mental health professionals that they interface with. While in practice, the relationships they have are less binary than described theoretically, the differences are felt through internal states of personal conflict as they negotiate the interface between legal guidance, ideological differences, pragmatic accounting of resources, values and personal feelings associated with their perceptions of professional risks to themselves. This is perhaps best illustrated by the discussion around service user led admissions and the contradictions in upholding the duty of care and maintaining human rights whilst having little power to directly control access to resources and being dependent in large part upon the diagnosis and actions of the service user.

In this study, I have used a critical realist theoretical framework as my interpretative lens (see chapter 4) and based on my findings, I argue that the AMHP uses a critical realist perspective in applying the mental health legislation in respect of assessments. I identify several frameworks that are drawn upon and suggest that together, these represent a unifying theory to explain the process of AMHP assessment. The component frameworks include conceptualisations of mental illness; the role of treatment; legislation and procedures and, notions of liberty and freedom. Within these frameworks, the AMHP has to balance concepts of risk, rights and responsibilities. There are also significant personal dynamics present based on the AMHPs personal values, beliefs, identities and experiences that inform their professional role and influence the dynamics of power with professionals, service users and their families. This power relationship is dynamic and fluid and there is a constant dynamic evident between the various actors. This process does not exist within a vacuum and social factors such as poverty, racism and class are evident. These wider structural factors including the prevailing political/economic environment create a landscape in which the impact of austerity both practically and ideologically are evident.

The AMHP works with these intersecting factors to negotiate a complex balance between rights and pragmatic realism to achieve the most appropriate outcomes for service users within a socio-medical/legal context that serves many, often competing, interests. The AMHP therefore also functions as a critical realist in that he/she is crafting contemporary mental health practice through a reflective lens coloured through the constructivist concepts of discourse, language and identity and, which is grounded both in current realities and historical specificities. These factors provide a new framework for understanding AMHP decision-making – one that moves beyond micro/macro frameworks used by individual AMHPs to one that enables an exploration of how AMHPs perform

their role and maintain professional and legal standards within a context bounded by factors out of their control – liminal agency.

To summarise the key and original findings of this research are:

- The research confirms that AMHPs use frameworks of understanding that shape their considerations during MHAs. These are previously developed schemas boundaried by the MHA criteria for detention and its CoP. The statutory considerations of mental disorder, its nature and/or degree are dominated by another framework of understanding that of risk.
- The AMHPs are most explicit about the consideration of the mental disorder, nature and or degree criteria and the least restrictive principle of the MHA. The other principles of the MHA are generally expressed implicitly in the AMHPs considerations.
- The AMHPs use frameworks of understanding that are critical of psychiatric positivism but accepting of the reality of mental illness, their approach places them within a critical realist framework of understanding. This critical realist approach is apparent in contextualising by the AMHP of the service user's behaviour to test alternative explanations. It is also apparent in the AMHPs requirement that there is a causative nexus between the persons presentation and perceived risk
- The AMHPs consideration of social factors was primarily an expressed belief that certain variables in the service user's life were protective or increased risk. The weighing and balancing of the presence or absence of protective factors was further evidence that the AMHPs worked outside a psychiatric positivist framework of understanding. Mental illness was viewed as a social problem more than a health problem.
- Risk assessment begins with the AMHP using frameworks of understanding that confirm or reject the service user's behaviour/presentation as being within the scope of a formal MHA. The AMHPs do not use prescriptive risk assessment tools based on an actuarial model, but they do have a set of risk concerns that they seek information about that are predeveloped.
- The identification of risk was often with a view to pre-empting actual harm rather than addressing existing harm. However, the process of making this determination also included the deconstruction of risk narratives that automatically associated the presence of mental disorder with risk.
- The AMHPs did not use prescriptive risk assessment tools although they share similarities with other AMHPs in how they construct risk frameworks of understanding and deconstruct these frameworks. The tools that were identifiable were the use of cautionary tales, counter intuitive interrogation and critical social perspectives. The AMHPs also wanted to ensure

there was a causative nexus between the person's identified mental disorder and risk concerns.

- The AMHPs tested the quality of the information by several different methods contextualising the information based on who was presenting the information, their relationship to the service user and how the information matched with other information.
- AMHPs considerations work across all three time dimensions and there is a dialectic relationship in how they interact. Present concerns are matched against past presentations, current concerns are used to predict future harms and the possibility of future harms are used to plan current interventions.
- The similarities in the approaches that the AMHPs took in constructing and deconstructing risk concerns suggest that they are not cherry-picking facts to justify predetermined outcomes. The consistency is based on tacit knowledge, professional wisdom and legal frameworks.
- The evidence suggests that all the AMHP decisions were taken within the boundaries set by the legal framework. The criteria for detention and the least restrictive principle were the elements that were most often expressed explicitly.
- The consideration of the least restrictive principle takes place in the context of other principles such as participation principles and other legislative concepts of the MCA. The AMHP uses a mixture of diagnostic concepts such as insight alongside MCA legal concepts of functional understanding to weigh the viability of less restrictive alternatives.
- The least restrictive principle was expressed most as an essential consideration, it was acknowledged by the AMHPs that its implementation was hampered by resource considerations and pressure brought to bear by others.
- The AMHPs expressed the belief that they do have a unique professional perspective that they value, including the legal authority to act independently of other professionals. They acknowledged that other professionals also hold unique perspectives which is something they seek to integrate into their decision making.
- The AMHPs expressed feelings of alienation relating to their role primarily based on the limited decisions they can make due to the lack of resources available to be able to implement other support plans.
- This alienation was also reflected in the AMHPs lack of control over the admission process including unavailability of inpatient beds and reluctance or refusal from other services to assist the management of compulsory admission.

- The AMHPs identified subjective factors such as the risk agenda that further increased their feeling of lack of control over the process when they felt unduly pressured to detain someone by the person's family or other professionals.
- The AMHPs expressed this as a paradoxical concern when undertaking MHAs on a person with a diagnosis of a personality disorder. The AMHPs expressed the belief that an admission was generally unhelpful for these individuals but the service users themselves held the power in attaining their own admission.
- The classic theory of alienation was identified in helping to explain the overall experience of AMHPs and the theory of malignant alienation was found to be applicable to AMHPs when assessing particular service user groups.

## 7. REFLECTIONS

### 7.1 Reflections on Methodology

This study adopted a bounded case study approach as a way of considering the various factors that influence AMHP decision-making. Consistent with the hypothesis testing methodology of the case study approach, I developed methods that would enable the hypothesis to be tested. While the testing of hypotheses is not usually considered appropriate in qualitative research, in case study research it refers to the identification of pre-existing theory that is subsequently explored within the research using either quantitative or qualitative methods or both. This was a qualitative study with the hypothesis in this case being the theoretical position that *the process of AMHP decision-making involves a range of objective and subjective elements which interact with the beliefs, values and experiences of individuals to inform and influence the decisions that are made in respect of mental health service users*. This theoretical position was derived from the preliminary literature review and is consistent with the critical realist approach, which proposes that there is an underlying objective intransient reality to the social world which exists separate to the conscious or transient reality constructed by social actors. By adopting a critical realist approach, I have been able to explore conceptualisations of mental illness and the role of treatment and, legislation; issues of risk, rights and responsibilities; notions of liberty and freedom; the dynamics of power in relation to professional roles and vis-à-vis service users; the role of service users in facilitating their own detention (self-referral) and the disruption of power this potentially represents; the influence of personal factors on decision-making (e.g. values, belief systems); social factors such as poverty, racism and classism and political/economic factors (e.g. the impact of austerity on the decline and availability of services). Uniquely, I have explored these as *intersecting* issues whereas other studies have tended to focus on single issues.

The semi-structured interviews and use of a vignette to structure the exploration of how AMHPs make decisions allowed for consistency across the participants regarding the factors they were required to consider. Although not an observation of real practice, the design of the vignette allowed the AMHP to consider information in stages which mirrors the process in practice. The way the interview was constructed allowed for different options to be considered and for the AMHP to confirm how each of the options would lead to different outcomes. The fictitious vignette used in the interview was designed as an exploration of the process of decision-making and not a test of an individual's

knowledge of the law. The vignette gave the AMHP a structure and familiar dilemmas to work with, whilst avoiding a focus on actual practice which may have pressured the AMHP into defending previous decisions. This method did not allow for exploration of real time pressures involved in assessments and this was therefore factored into the analysis.

AMHPs did comment that there were aspects of the vignette that were familiar to them or that they had had similar experiences, initiating discussion about how they had proceeded in those circumstances. The interview method led to a single continuous narrative, which contained key information an AMHP would need to consider in the decision whether to undertake an assessment, how they would undertake an assessment and what could lead to a decision to detain. There was a degree of flexibility allowed for the interviewee to enable them to play with the vignette and consider how different factors might affect their decisions. However, by keeping to a single continuous narrative, comparisons could be made across the case study of how different individual actors considered and made sense of the information. The AMHP was asked to consider and make decisions and subsequent analysis of the transcripts revealed a dialectical process as the AMHPs hypothesis was constantly checked and updated dependant on the behaviour or beliefs presented by other participants. All the participants concluded with the detention of the person, not because this was a conclusion, they came to automatically but because they were asked to eliminate options until only detention remained. Each of the elements of this process could therefore be identified and compared for similarities and differences. It was not within the original scope of this research to undertake a comparative study of AMHPs based on age, gender, professional background etc. The purpose was to discover the factors considered and affecting AMHP decision-making and any consistent themes or patterns that emerged. This included identifying consistencies of process whilst at the same time, being able to see variations in method of consideration, evidencing the presence of intransient and transient factors in the decisional process.

The focus group discussion was designed to explore the more transient element of decision-making and how beliefs and values play a role. The expression of views and exploration of beliefs by the participants illuminated the process by which subjective beliefs and values underpin practice. Although the discussion began with the very tangible issue of the law as a legal safeguard, this was quickly subverted by questions of what objective reality is and what can be claimed to be true in mental health work.

The freedom to discuss the less conscious or subjective systems of beliefs allowed the AMHPs to question their own life experience, their socio-economic view of the political economy of AMHP work and how their perception of expectations of them often contradict their own view of their work and role. This was expressed as ideological conflict with other professional groups, political discontent at the lack of tangible resources and the subsequent alienation they sometimes experience in relation to the service users they believe they are trying to help and give support to. Because the focus group was able to consider more than the structure of an assessment, it allowed interpretive exploration by the AMHPs of their transient reality or what they perceive to be true. The combination of the two methods of inquiry within the same methodological position has given additional insight to the objective considerations AMHPs believe they are applying and the subjective beliefs and values which inform these.

This research, like all research, has its limitations and its strengths. The number of participants in total was 25 and therefore relatively small in comparison to the entire AMHP workforce across England and Wales. It was limited to one locality in which all the AMHPs were social workers by profession. Therefore, there was no comparison possible with decision-making of AMHPs who were not social workers. The perspective gained is therefore unique to this particular group of AMHPs.

The study was not a quantitative study and the methodology provides the rationale of why the number of AMHPs was limited and kept within a bounded case study as discussed in chapter 4. This limits generalisations from the research findings but has allowed for a more in-depth analysis of the decision-making of this group of professionals.

Future research or an alternative scrutiny of the data might look at the demographics of the respondents in more detail and compare possible themes arising from this. This could be based on gender, ethnicity, age and experience as an AMHP or previous experience as an ASW. The purpose of this study was to identify factors that affect AMHP decision-making, but future analysis could consider the impact of demographics.

The study was undertaken using a single vignette, the use of observation could have provided evidence of the process of decision-making as it naturally occurred that factored in real time pressures

and factors. It may also provide a wider variety of circumstances and presentations to allow a different set of comparisons and analysis. Although a follow up interview would still probably be necessary to determine what thoughts were behind the participants' actions and the concerns about the impact observation would have on someone experiencing a mental health crisis would remain. An alternative to direct observation may be the inclusion of video material to ask the AMHPs to comment on or asking them to talk specifically about actual cases they have previously been involved in. All of these methods would bring with them limitations and strengths that would also need to be factored into the analysis.

This research has opened a plethora of other avenues of inquiry that could be explored. One area of study could be the origins of AMHP knowledge and how they develop the frameworks of understanding that they apply to this process. The AMHPs spoke at length about the limitations of medicalised approaches and solutions, it would be useful to develop an understanding of what they believe an alternative social perspective could offer. The risk agenda was a strong element throughout the findings and there was a distinct difference between the ways in which risk was considered in the vignette as compared to the discussion about people who were thought to be attempting to engineer their own admission. This would also be an interesting area to undertake further research.

The role of the insider researcher also needs to be acknowledged as a potential limitation and a strength in this research, this is discussed next.

## **7.2 Reflexivity: Insider Research**

My continued role as an AMHP and an AMHP Professional Lead has had an inevitable impact on the way I have constructed this study, gathered the data and analysed the findings. A reflexive approach needs to consider the strengths and potential drawbacks of this reality. By being an insider researcher, there was a familiarity with the language, culture and parameters of the role of the AMHP. This familiarity provided strengths in interpreting and examining the material; at the same time there was the possibility that as the researcher I could have been too close to the subject area. This can lead to identification with the subject and the limiting of the researcher's ability to take a naïve approach to the material. There was also the possibility, that because the participants were aware of my AMHP

status, they may have tailored their answers to state what they thought I wanted to hear or, they could have used a shorthand form of language to describe complex decisions. By being aware of these possible reactions and through the use of reflexive supervision I consciously tried to guard against some of these drawbacks (Humphries, 2003; White, 1997). One example of this was identification of self-referral of service users and the perception that some groups were trying to bring about their own admission. The importance of this finding and the need to further explore this issue was developed in supervision. This required me to return to the literature to be able to theorise what might be happening in the dynamic between the service users and the AMHPs. Without this external safeguard of supervision, I may not have been able separate myself from the emotive feelings and experiences being described by the AMHPs. This may have led to either feeling the need to be defensive or overly critical without seeking to understand what was going on within this narrative.

The insider nature of this research has required me to continuously reflect upon the material as I transcribed, interrogated and analysed it. The discussion about service user-led admissions was an unexpected element of the data and required a re-examination of the literature to be able to theorise the beliefs and feelings expressed. The ongoing review of the literature has introduced me to research and concepts that have challenged previous perceptions of the work I undertake and the decision-making of other AMHP colleagues. The process of research design impresses upon the researcher the need for them to be able to substantiate contentions and, in the context of critical realism, defend the notion that there is an intransient reality whilst accepting the interpretation of this is undertaken by AMHPs who are subjective social actors working with and creating their own transient reality.

Understanding of the culture of AMHP work and the context, has been a unique factor in the exploring of their decision-making. As the researcher has experienced, when undertaking the AMHP role, they consider themselves to be partially separated from their other mental health work and the work of their non-AMHP colleagues. Having cognisance of this and the nuanced difference between AMHP work and other mental health decision-making gave a unique insight. As suggested by Babbie & Rubin (2001), there is an inevitable subjectivity to any research but more so when the person is an active participant in the area. This has required me, as a researcher, to reflect on the limitations of my objectivity and, at the same time, recognise the insights into the material that might be missed by a non-participant researcher (White, Fook, & Gardner, 2006). The role of the AMHP is complex and nuanced and, though governed by national legislation and universal human rights obligations, is also impacted by the constraints, opportunities and organisational cultures specific to local contexts. The aims of this research were to develop understandings that will be applicable to AMHP practice and to

obtain data about professional practice. The insider knowledge of organisational politics, the varied roles of the AMHP, understanding gate keeping and procedures for negotiating access to services has been invaluable in the interpretation of the data gathered.

In the same way as the AMHP is considering multiple factors in any situation within a fluid and changing landscape, the AMHP researcher has to also consider that over the period in which the research takes place, their own material environment is in the process of change. This affects the researcher's thinking and practice and therefore has an impact on how the insights they develop translate into an active research process. As an AMHP practitioner, AMHP Professional Lead and educator of AMHP trainees, my theoretical understanding of my area of practice has changed and I have developed new insights. This testing in practice and scrutiny of the practice of others, allows for the development of further insights into practice and also further scrutiny of the research material.

### **7.3 Contribution to Knowledge**

The original reason for undertaking this research was a long held personal question regarding the role of the AMHP, previously, ASW. Although AMHPs are not exclusively social workers, their role draws from a long-term tendency for social workers to be the dominant profession. As a social worker and an AMHP, I wanted to know how other AMHPs made decisions about possibly depriving someone of their liberty, whilst holding a professional qualification that is based on the understanding of unequal power relations in society and the promotion of autonomy for the people we engage with.

The unique contribution that this research makes is that it is undertaken by an AMHP practitioner researcher using a critical realist perspective to design the research, undertake and analyse it. The tendency I have tried to avoid is to err towards an unqualified defence of the role of the AMHP and the decision-making of this group of professionals. The approach I have taken is to present the views of the AMHPs and neither defend or overtly criticise these but try to understand and contextualise the themes. The research methods were designed to allow the AMHPs to speak for themselves and retrospectively identify the themes of what they say and the meanings that lay behind them. This has been a process of peeling away the layers, beginning with actions and their perceived intentions. The use of semi-structured interviews with a vignette highlighted the structured process of thinking and problem solving that appears to be consistent with all professional groups. The consistent elements

here were adherence to a legal framework, the dominance of the risk agenda and distinctive similarities in what AMHPs believed were causes of concern.

The AMHPs in this study, expressed a dichotomy in terms of epistemology (although they would never use this term) and seemed to concur that psychiatric positivism is fundamentally flawed. They consistently challenge its beliefs about diagnosis, prognosis and treatment. They are reticent about the efficacy of psychiatric hospital admissions which, at best, they believe provides asylum for the patient from social pressures. At worst, they view admission as a process that labels the individual as a psychiatric patient who will, from now on, be treated within the confines of medicine. The AMHP therefore also functions as a critical realist in that he/she is crafting contemporary mental health practice through a reflective lens coloured through the constructivist concepts of discourse, language and identity and, which is grounded in social realities. The choices for the AMHP are however, limited by legislation and equally by the resources and options available to them. They are aware of their right to make independent decisions which is something they strongly value. At the same time, they are aware that they make independent decisions but not in circumstances of their own choosing. All the AMHP who participated in this research seemed to hold a critical view towards psychiatric positivism and believe that part of their role is to bring an alternative social perspective to bear regardless of how influential this perspective is. The interaction of the focus group demonstrated this peculiar and often contradictory nature of AMHP work, which draws very much on the personal in terms of human relationships and personal identification with those experiencing mental distress, while at the same time, the AMHP can be construed as the person's potential jailor.

The issue of legal compliance, or legal literacy, of the AMHP is something that is under scrutiny in the literature. One of the things that the findings of this study illustrates is the belief by the AMHPs that they hold a legally independent role. Although this research would confirm that AMHPs do not always express their decision-making processes in explicitly legal terms, the legal framework of understanding their evidence in practice strongly approximates to the legal requirements and principles of the MHA. This research also confirms the belief by AMHPs that their work is, in many ways, distinctive from other mental health professionals and is maintained through what they see as a distinctive professional culture. It also confirms the findings of others that there are strong subjective elements to their decision-making, based on their intrapersonal feelings and inter professional tensions and interactions with the expectations of others. The AMHPs also confirmed in this research that the constraints on the decisions they make and the negative personal impact on themselves, and the

people they seek to help, are compounded by a lack of resources, particularly as the cohort of AMHPs are operating within an epoch of austerity.

It was not the aim of the research to prove or disprove the research findings of others, or to only identify factors that were entirely unique. As a bounded case study undertaken in a particular locality, it was also desirable to see how or if the findings of others could be applied in this particular context. This was certainly the case in relation to the belief that AMHPs, like other decision-makers, use frameworks of understanding to gather information, consider and weigh that information when making decisions. This research identified significant frameworks such as risk, and the management of risk, as a consistent feature in the decision-making of AMHPs. There were also other frameworks of understanding being applied consistent with their perceived view of themselves and their role. AMHPs viewed themselves as defending a model of understanding mental distress that is critical of psychiatric positivism, which requires them to have a range of critical tools in their toolbox. To summarise, the AMHP's view of their role is best described as bringing critical scrutiny to bare but only within legally and ideologically created boundaries that automatically associate risk and mental illness. Thus, the AMHP has to negotiate a complex balance between rights and pragmatic realism to achieve the most appropriate outcomes for service users within a socio-medical/legal context that serves hegemonic discourses of mental illness.

The implications of this for policy and practice are that if the AMHP recognises that they use frameworks as a way of making sense of a given situation, it is imperative that they take a reflexive approach to the development and critical analysis of these frameworks. It is evident that risk is a key determinant in the development of decisional frameworks and in order to ensure that these risk frameworks are applied fairly, an appraisal of how they are constructed should be undertaken. This could include a more objective analysis of actual harm occurring by people experiencing mental ill health balanced against the iatrogenic effects of becoming a mental health patient.

Another implication for practice is the need to equip the AMHP with the resources to apply the 'least restrictive' principle in practice. The AMHPs describe at the point of assessment, feeling that the alternative is often an inpatient admission or referral to HBT. The limitations of what they are able to achieve through this are highlighted by the AMHPs perception that there is a paucity of culturally sensitive services including the very basic requirement of a consistent interpreting service. There is also the perception that there are certain service user groups who are fitted into a medicalised

approach to mental distress which leads to repeated admission to hospital. The conclusion to this suggests a critical review of how services are provided to better meet service user needs *outside* of a hospital or medicalised environment.

The personal impact of the role also needs to be considered, whether in dealing with the person's mental distress or because you hold responsibility for the person's safety or the safety of others. The AMHPs express an awareness that they hold the ultimate responsibility for making decisions that have significant implications for others. The time and space to do this effectively in a much-pressured service would be a significant positive development. This research has enabled me to develop as a researcher and also a practitioner. The extensive reading of research and scrutiny of my own material engenders an approach to MHAAs that is critical and questioning. I have already incorporated many lessons from this into my practice and into my teaching of AMHPs. My future plans are to continue presenting my findings at research conferences and to present my work for publication.

## **8 APPENDICES**

### **8.1 Conference Presentations**

Voices of Madness History Conference - University of Huddersfield 15-16<sup>th</sup> September 2016

White Rose Doctoral Training Conference - University of Sheffield 6<sup>th</sup> July 2017

National AMHP Leads Network Conference – London 10<sup>th</sup> July 2017

Post Graduate Research Conference – University of Huddersfield 27<sup>th</sup> June 2018

AMHP Research Network Conference – Birmingham 14<sup>th</sup> May 2019

International Academy of Law and Mental Health Conference – Rome 21<sup>st</sup> July 2019

Future; European Social Work Research Conference – Bucharest 22<sup>nd</sup>-24<sup>th</sup> April 2020

## 8.2 Transcript Examples

### Participant J1

AB I am going to ask you to think about how you receive a request for a Mental Health Act assessment. I will ask you about what information you would expect to receive and how you would proceed. I have a fictitious scenario to work through and I will give you the information as you request it. I will also ask questions for clarification as issues arise. This is not a test of your knowledge and is intended to prompt discussion about how you as an AMHP would respond to the issues you are presented with. You can ask for the information to be repeated at any time, please feel free to take notes and refer to the Mental Health Act Manual, Code of Practice or Reference Guide provided. There are also some supplementary questions I may ask as we progress. So, the first question then is about how you as an AMHP would receive referrals and what kind of information you are kind of looking for at that point.

J1 Well there a different ways – usually if I’m on the rota for example I will either get a phone call from the rota co-ordinator who works for the Council who filters whether something or not is an assessment and then they often bat a lot of them away once it gets to where they think it is a Mental Health Act assessment they will give me a call and give me the information that they have which varies depending on what they have been given. Sometimes I will just get someone’s up on the ward their on a Section 2, they’ve got a recommendation for a Section 3, this is their name, this is their address very brief outline of why they are there in the first place even if that sometimes, and I will get a telephone number, a date of birth and potentially a RIO number. So I will know what ward they’re on so from that I know that I can phone the ward who will have a case file on them and there is a RIO system that I can get people to look at for me, and give me some feedback for that. I also get referrals directly from my team, I work for the Learning Disability Team. If there’s somebody we are working within our team who is deteriorating in their mental health and we have got experienced staff members, nurses, social workers health care support workers, manager and an outside community team who have contact with people in the community like OT’s, physio’s psychiatry, nursing and also care providers . So within that whole network if someone gives me information that someone is deteriorating especially if its someone I know as well and they’re asking me to become involved because I’m an AMHP and I know the person I will get involved in that way, we can put alternatives in, test things out really make sure that it needs to be a Mental Health Act assessment before it becomes one, so I can ask questions like has

this been done, what have you done here, have you followed this, have you asked this, have you tried this and then it's more of a steady sort of progress getting towards an assessment. I can then work alongside me team members like that, another way of getting them through is from Social Care Direct which is our telephone call centre which receives all the referrals and if I'm on the rota they will be notified of that and if they get a Mental Health Act assessment they will contact me, they will give me what they have received from whoever the alerter is so all the personal details they will have, usually address, date of birth, telephone numbers, they will know a brief story of what's gone on with the person. If it's a new referral, if it's someone completely new to services it will probably have been vetted a bit more. They will have a better amount of information to give me, sometimes it might be that someone is up on the 136 suite, the local 136 suite and I will get basic information like I said before, date of birth, name and a brief story of how they have come to be there and I will obviously have got contact details off the 136 suite and call them up and find out more as they have usually got more as they have spent more time with them. I might then get asked by colleagues within my service someone sent an email round the other day saying they need an AMHP to do a Community Treatment order, consider it so between the AMHPs in our service we will decide.

AB So you get varied places that you will get referrals from and you will get different information depending on where that information comes from. As an AMHP what kind of information are you wanting to make the decision about whether you kind of progress to organising an assessment or whether you go down another route.

J1 I want to know as much information as I can possibly get, I often find that I will get a lead, get a number, I often describe it as you get given a few pieces of the puzzle at the beginning of the day and then random and on part of that piece of the puzzle you will get given a phone number or a name and you phone that person and they will give you a little bit more of the puzzle and that will lead you to another phone number or another name and you find out who that is and you phone them and throughout the day you get a number of different pieces and by the end of it you've got all the pieces and they are all on the floor in front of you and you've got to sort of work out what the picture is for yourself. You know what everybody else is saying within their own little pieces but to put it together as one big picture I have got to do that for myself at the end.

AB So if I give you a bit of information about the initial referral then and see where you go with that. So, you receive a call from Social Care Direct, you're an AMHP on the rota or from the co-ordinator. Mr X is a 37-year male. Lives alone in his own tenancy. Is known to community mental health services. He has missed his recent appointments with his care co-ordinator and

outpatient appointments. Neighbours and family are expressing concerns that his mental health is deteriorating. Concerns include Mr X shouting at his neighbours and family stating that “everybody is out to get him” and “if people don’t leave me alone, I am going to end up in hospital”. A Mental Health Act assessment has been requested by his community mental health team. That the basic information any kind of thoughts at that point about the information you have been.

J1 I haven’t got much, I never heard you mention anything about historical, you say that CMHT are involved but I don’t know why they are involved, you know. They are involved for a reason, but I would want to know what that reason and how long they have been involved for. What it is that they have done in the past has he been in hospital before, has been under any sort of Section of the Mental Health Act. Why are they concerned about that because that information they have given me at the minutes is just him shouting at people and he’s not wanting to see anyone. I haven’t really got any information about it being linked with him being mentally unwell. Because of who was asking for it, it was suggested that there is a link, and it would need more digging but I would need more information. How effort have they actually put to go and see him, how many times have they tried to go round, are they going round at the wrong times, why doesn’t he want to see them. It doesn’t necessarily have to be linked to his mental health he might just not like them. There’s loads more information I would need.

AB So at that stage that’s not something that would necessarily trigger an automatic Mental health Act assessment.

J1 No not necessarily.

AB You would want more information, so where would you go for that information.

J1 Well you mentioned CMHT and they put the referral in so I would call them, they will hold a lot of information about him.

AB So shall I give you some information that they hold – I won’t give you it all at once so we can kind of go through bits and kind of see what happens in terms of your thinking. Information from Community Team - Mr X has been known to CMHT for approximately 10 years. He has a diagnosis of bi-polar affective disorder although his care coordinator informs you that on a previous admission nursing staff expressed the belief that his symptoms of hyper-mania were caused by misuse of illicit substances and his presentation was more suggestive of an emotionally unstable personality disorder. Mr X has had three previous admissions to hospital: one informal voluntary admission, lasting about a week. Mr X discharged himself on this occasion. On the second occasion he was detained under Section 2 of the Mental Health

Act, on this occasion he became an informal patient after three weeks and was discharged from hospital after four weeks. It was during this admission he was diagnosed with Bi-Polar affective disorder and he was started on mood stabilising medication. His latest admission was three months ago, he was initially admitted subject to Section 2 MHA later converted to Section 3. The explanation for this detention under Section 3 is that he refused to accept his diagnosis and need for medication or support from community mental health services. Mr X was discharged from his detention under section by a Mental Health Review Tribunal. At his tribunal Mr X stated that he accepted his diagnosis, he was willing to take his medication and accepted support from the community team. Mr X also stated that he had used cannabis to help him relax but now acknowledged that his drug use may have contributed to him becoming unwell. That's the first bit, what's the kind of thoughts you have around that information.

J1 There's a diagnosis, he's been in hospital for periods of assessment, been assessed by clinicians who've given him a diagnosis so there is potential there for a link to a mental disorder and concern around his recent behaviour, he's not accepting the diagnosis, a lot of people don't. They think he might have other mental disorders like personality disorder, what else did you say.

AB he was diagnosed last time as Bi-Polar affective disorder but the nurses on the ward thought that it's more suggestive of an emotionally unstable personality disorder and also misuse of substances.

J1 Did you mention hyper mania as well?

AB Hyper mania is a symptom I think, symptoms of hyper mania.

J1 So they are suggesting it need more assessment, because that was determined at the last period of time in hospital. There's still not much about what he's actually doing, alright he's mentally unwell but, he doesn't want to see them, why is it just because he doesn't want to see them why does that automatically take it to be a Mental Health Act assessment, there might be reasons he doesn't want to see them. Maybe he's having a hard time at the minute in his personal life, maybe he's split up with someone, maybe there's problems in the family, maybe he's tired you know we need that bit of information but he's shouting at neighbours, why is he shouting at neighbours it's there tension between him and his neighbours, are the neighbours speaking to CMHT, is there more information about what's going on in his behaviour.

AB OK – so shall I give you a bit more information? There are his previous symptoms. When unwell Mr X is described as being volatile in mood. He is confrontational with his family and

neighbours. He accuses them of interfering in his life and has on occasions made allegations that people have been in his flat and read his mail, moved things around and taken things without his permission

Mr X has been separated from his wife for approximately 12 months although she did not leave the family home until his recent admission. Their two sons aged 10 and 15 live with their mother although they continue to visit Mr X and stay overnight at the weekends. Mrs X has previously stated that she loves Mr X but she had left because when he becomes unwell, he repeatedly accuses her of having affairs. She has stated that his periods of illness are disruptive and distressing for their sons.

He has a history of cautions from police for anti- social behaviour towards his neighbours and members of the public.

Mr X has a history of expressing suicidal thoughts in the past when low in mood. He has taken two previous intentional overdoses; the last occasion was 11 months ago.

J1 So 11 months ago his wife split up with him 12 months.

AB His wife split up with during his last admission. It was within 12 months ago that she left the family home until his recent admission.

J1 So the suicide was a month after she had gone. So that springs to mind, I mean what I know is what the family are saying because you said that there's children going to see him every weekend, so they have got good contact with him, he might not be letting us in but he might be letting them in and it sounds like his wife believes in his diagnosis. It's a big part of the reason they have split up, it sounds like he probably going to have contact with her because

## **Participant H1**

AB The CMHT haven't had any contact with him, you said about information from family, I have got information from 3 family members, that you've got to consult, or might be available to you via the team, there's his ex-partner, his mother and his sister. Would you want any of that information?

H1 Yes please if you have already got it.

AB Who would you want?

- H1 I would like to hope that CMHT maybe has got that information, or they have passed that on because they obviously passed it somewhere.
- AB Ok so this may be come direct to you or via CMHT. Mrs X does not want to discuss her ex-husband. Her sons are continuing to visit their father, they haven't expressed any concerns to her just to say, "Dad is Dad, what do you expect", when asked how he is. She informs you that if she is worried about the boys, she would stop them visiting their father. So that's the information from his ex-partner, his mum? So here is the information from his mum. Mr X's father died 10 years ago. Mr X's mother described the relationship with his father as strained and there were lots of arguments between them. She informs us that her deceased husband was a heavy drinker and could on occasions be verbally aggressive and physically violent. Mother describes her son as loving and caring towards her and his children. She believes that many of his problems arise from his marriage and that his wife was too critical and controlling of her son. She doesn't know what is wrong with her son but described him as "a bit of a dreamer" "he didn't get on well at school", "likes to keep himself to himself". She informs you she doesn't think he is looking after himself and worried that he isn't eating properly and looks tired all the time. She doesn't want to be responsible for "locking him up" but thinks "the professionals should decide what is best for him".
- H1 OK – so we have got concerns around neglect, question mark, and how often does she see him, did she say when the last time she saw him?
- AB It does say but it does say that she doesn't think he's looking after himself and is worried that he isn't eating properly and looks tired all the time.
- H1 Mother's worry – ok.
- AB So here is the information from his sister. Mrs A believes that her brother is very unwell and needs to be in hospital. She describes him as very hostile towards her and paranoid about the family. She is close to Mr Xs ex-partner and states that it is unlikely that she has had any relationship with other men. She is worried about the strain his behaviour is creating for their mother and informs you that her Mum has always covered up for her brother. Mrs A is adamant that her brother should be in hospital before he hurts himself or somebody else.
- H1 Right – can you go back to that bit again
- AB Which bit is that?
- H1 Read it again, Mrs A believes that her brother is very unwell and needs to be in hospital. She describes him to be very hostile towards her and paranoid. Right so there's a question mark here that she's saying that its states that it's unlikely that she's had a relationship with other

men, so presuming that he's accused her of having affairs whether it be now or in the past, so she believes that he's hostile.

AB So giving you the information you've got at the moment, where are you in this process.

H1 Still gathering information, a lot of my decision making is going to be on a lot of the people that know this man well. I guess to a degree I would be asking the CMHT – who's requested that I do the Mental Health Act assessment?

AB CMHT

H1 The CMHT, right, so if the CMHT has requested it at this stage and we have got significant risk I would potentially be considering doing it, but the key to me have they already been round to the house and tried to engage with this man, because to me I would be thinking it's better to go round and do it nicely nicely than 2 Doctors and a social worker turning up on your doorstep, and how am I going to get in the door anyway. So would need to know if we can get in for a start and try and engage with this man.

AB So you for you there would be something before a Mental Health Act assessment if they hadn't tried to engage, but if they had tried to go to his house and had been repeatedly unsuccessful.

H1 Then it would have to get to that point.

AB So what would convince you at this stage that a Mental Health Act assessment was necessary?

H1 Repeatedly try to engage with this man, evidence from the CMHT that they have seen that this man is potentially hostile, neglected and potentially isolated and not willing to engage. Do we know if he is eating, do we know if he is going out, what are the risks, what do they think the risks are, do they think he is hostile to his family or is it just specific members of his family who he has a relationship maybe his ex-wife, there are questions marks there but the boys are going round and they're aged 10 and 15, is there anyone else getting in that house besides those boys. That's a real question mark isn't it, but if nobody else is going in besides those boys who's measure that risk, it's ok the ex-partner letting those boys go in she's having nothing to do with him so how's she measuring that risk and suitability, you know she's got parental responsibility but that's a question mark and has CMHT already explored that, you would like to hope so, but you know we have limited information, I don't know that so those the kind of questions I would be asking are there risks to the children as well.

AB So if you were minded to undertake a Mental Health Act assessment, if the risks were significant and the information was significant what would you do now, what would be your next step?

H1 Liaising with the CMHT, to get to see this man, when could that be? Usually when it comes to the rota they request it there and then, they are wanting it now, and when it usually gets to

that step but not always but a lot of the time it does so my steps would be to gather information from the GP, asking when you last saw this man, is he picking up his medication, looking at risks that way, has anybody seen him in surgery, can you attend, especially if he's got physical health stuff going on. That's not always possible, it might be a lot of time that the GP doesn't know their patients or they can't attend, getting the Doctor who would know this chap, does the CMHT Doctor know this chap, who saw him last, so try and get a Doctor who's familiar with him, and having that conversation. Sometimes the last Doctor who had a conversation with this bloke is the ward Doctor so maybe the ward Doctor would be the one that would be most appropriate.

AB So in terms of you getting you Doctors to the assessment you would like to look towards the GP and you would look towards possibly a psychiatrist from the team, or a psychiatrist that's got previous knowledge of him.

H1 Yes

AB What would be the reason for going for a GP?

H1 To be perfectly honest, most of the time I go for the GP is that the GP is familiar with them, if ideally a lot of the time they have information about their physical health, this chap is 37 so they will probably having physical health problems lessens but a lot of the time in older adults it is absolutely key especially with a lot of physical health stuff times he's been to see people and it's been around their physical health as opposed to their mental health so it doesn't warrant a mental health intervention or sometimes if people have to be detained also to physical health bed as opposed to mental health bed then you have got someone there that's key in that process. They hold a lot of information that sometimes we don't have around medication etc., but a lot of the time unfortunately the GP's are not available. I don't spend a hell of a lot of effort in chasing GP's unless it's an older adult.

AB OK and then in terms of the psychiatrist so it would preferable be one that has known him before, what's the advantage of that.

H1 They've got background information of this person, they've got a measure, they've seen this person previously so can measure against how is he is now, and they can compare risks. They can also engage with them, if a person sees a friendly person that's always a lot better.

AB So you've got your 2 Doctors, what you need to do now in terms of undertaking that assessment, what's the consideration in undertaking that assessment?

H1 Time, bed if necessary, if we're getting to the point of a Mental Health Act assessment the best place I would phone is the Crisis Team and tell them were going to undertake an assessment, have we got any beds. What have we got available, where is it, hopefully if we

have got one then that opens up a lot of door, but if we haven't then tell them you might be a bit later because we have got to go for a private bed, you've got to make sure that all the risks assessments etc. are up to date so if that's the case I would be asking the CMHT worker to ensure that was all up to date because it blocks things later on. What else am I considering, timings of Doctors, I would also be considering who my Doctors is and skills of the Doctor, that is something I always seriously consider because some Doctors give different assessments to others, some go more in depth and look at things a lot more holistically including social aspects where as other Doctors don't, yes he's unwell and he needs to come in, which is unusual. What other things do I need to consider, I consider how I'm going to get in, how's this guy going to open the door to me, is he in, what's his patterns, is he usually there in the afternoons is he usually around, we need to consider the children, are the kids going to be in this house, because if the kids go after school at half past 3 we need to be making sure that these kids don't come back and end up in the middle of an assessment but to a degree it could be an advantage knowing that these kids come back at half past 3 he is likely to be in. So, you know we are trying to find out when he's in etc. I want to know the risk assessments; we've talked about volatility and confrontational how volatile and how confrontational is this guy and risky in the past.

AB I am just going to give you some additional information. Mr X does not have any criminal convictions for violent offences. There is an alert on his case records that he physically assaulted a healthcare professional during a previous admission. Mr X has said there is no way he will ever go back to hospital. He has said to his mother that he will "run away and no one will ever find him, if they try to lock him up again".

There are currently no in-patient beds available locally.

H1 OK – if that's the case I would wait until we've got something, because the reason I say that is we're going to have a limited amount of time and I have got to consider as an AMHP the time we do an assessment your left with the baby if you like, and I don't want to be left in a volatile situation and neither is it fair for that person because at that point if they know they're going into hospital that's when things can either calm down very quickly or escalate very quickly when the decision is made so I would be considering that. If he's been quite volatile in the past, I wouldn't necessarily be thinking I need the police but I would certainly be thinking I'm going to get my timing a bit better here.

AB In what respect.

H1 In that we might not have a bed, because sometimes we've done a Mental Health Act assessment and we haven't got a bed until 11 O'clock at night and I will be asking questions

does it have to be today, what is the risk is this man seriously going to hurt himself or others or is this neglect that possibly a day won't necessarily change and is it better that we wait a day until we've got a bed, before we upset this man even further and potentially deteriorate very quickly.

AB OK - so a bed is available.

H1 Right you've got a bed

AB Right we've got a bed so in terms of actually getting out there and undertaking the assessment what happens now.

H1 We agree a time, we've hopefully got some kind of plan to get access, so we've hopefully got someone who knows him to get him to open the door ideally before we start looking at other options. Then getting Doctors to arrange to go, we've probably got a time hopefully no kids in the house, all those things considered with Doctors to meet at a certain time and we're all ready to go and knock on his door.

AB OK – who knocks on his door?

H1 The AMHP every time. Why do I say that – because the Doctors push the AMHP's down the route pathway, I've seen many a time and a lot of the time I think we will go as well because why do I say that because of language barriers etc. because a lot of our Doctors are not from Yorkshire. I'm not trying to be thinking, because sometimes getting in a door and knocking on a door its need an "ey up how are ya" – "you alright, just checking to see how ya are cause heard ya not right well" and that will get you through better than hello I'm Doctor you know so and so and an ey up getting you through the door oh and I've actually brought the Doctors with me as well, usually comes the second part when I've got 4 steps in the house.

AB OK – Mr X is at home when you arrive. He speaks to you from the bedroom window. He states that he's fine and it is everybody else who needs locking up.

H1 Ok – well engage in conversation. Engage in something "you alright ya got food" try and get some banter going.

AB So Mr X eventually allows you into his home. What happens now?

H1 First of all we will try and start some banter of how are you, and then hopefully tell him the reasons we are there.

AB Who would do that?

H1 Usually the AMHP – depending on the Doctor that you take, a lot of the time if I've got to have certain Doctors because of the familiarity I'll choose certain Doctors who I know are very good at engaging with people. So, a lot of the time it's usually myself, usually the AMHP but depends on the Doctor.

- AB And how does that process proceed?
- H1 Usually go round – it depends on how that person is, to how much detail goes in to. Some people want the thread to the needle so what rights have you go to come here, depends on what that person says we generally say you know we've come to look at the options and to help you and say that because we haven't been able to work with you, do you want me to say what I would say or.
- AB Just in terms of the process and how you can go through that process of assessing this person.
- H1 Just initially say why and the purpose of you being there, and then just lead with am I here, how have you been managing, no one has seen you. Usually just start it that way, and Doctor might have some questions to ask you as well and things so I usually let the Doctor, so I usually start; it may be opening how are you and start it all flowing then generally the Doctors ask their questions.
- AB OK - Mr X is agitated at the start of your interview. Informs you that he feels he is being constantly monitored by others and that your presence is making him feel worse. G1 X believes that his involvement in mental health services has been a mistake and that his behaviour is different to other people but being different to other people is not a problem. Mr X states that the neighbours don't like him because he is different. He accuses them of racism and states that liking Reggae music and smoking cannabis is his only crime. Mr X believes that the housing association want him out because he is a single man in a 3 bedroomed house.
- H1 Well what he's saying is we look to find evidence for – you know he's saying what leads you to that and exploring everything that he's said. You know where's the evidence for this what he's saying you know, and whilst doing that and engaging I want to know what his functioning is like, what's his flat like, you know has he got food, has he got food in the fridge, has he been out, is he kempt you know you are looking at all the other stuff that he doesn't say as well. What's his level of functioning like what does he do day to day? I suppose from my perspective I leave the Doctor to do the Mental Health diagnostic stuff with obviously our experience in Mental Health but I interested in functioning day to day and how is this man managing, because he might have a psychosis and an awful psychosis but that doesn't mean that we can't get in there and make it and work with him with him having to be in hospital. So, I would want to know what are his concerns and his distress and what is causing his distress.
- AB OK - Mr X believes the police are working with the housing association because none of them want his "type" in the neighbourhood. Mr X does not accept that his family have genuine concern about his wellbeing. He believes they are working with his ex-wife to get him into

hospital. He believes his ex-wife plans to move back into the house when he is in hospital and change the locks. Mr X believes his ex-wife is having a relationship with the housing association estate manager and they have “cooked up this plan together”. Mr X states that his ex-wife and the estate manager are members of a secret organisation “The illuminati”. He states the belief that he thinks his sister may also be involved and it’s a well-known fact that mental health services are under the control of the “illuminati”.

- H1 He might not be wrong, his ex-wife might be trying to go in the house and change the locks even though her name’s on the tenancy, or if he owns it absolutely she could do quite easily, so that might not be there. It depends what he’s saying, it sounds to me like a psychosis to a degree but what are the risks for this man, he might have been to the shops, he might have a cupboard full of things, he might be looking forward to his kids coming back, he might not mention the illuminati when the kids are there. I would want to ask him about his relationship with his kids, it’s around his functioning a lot as well and saying “alright I hear what you’re saying” it sounds awful you know that you think your ex-wife is getting the house you know but and being honest and putting it on the table however, X, Y, Z people around you are raising concerns why don’t you just work with us, let’s work with us around this and we will help you because it sounds like it’s really distressing to me, and let’s have a look at that, you know, our last option is hospital and try and work it that way I guess rather than having to go for detaining someone. It’s depending on what they say, so whether that be a CMHT or Home-Based Treatment or depending on what he says that leads us to, thinks that it’s very significantly risky.
- AB So that’s really looking at where I was going next in terms of your options, so you’re saying in the first instance what’s the first option that you would look at.
- H1 CMHT – you would hope that a CMHT worker is with me saying look you know I’m here.....you know and hopefully they’ll you know if you like take a bit more of a lead at that point if necessary if this man’s engaging and he is prepared to engage with them, you know because if the CMHT say we’re here to help you we’re not here to help your ex-wife whatever and hopefully that’s the way to go.

## Participant G1

AB I will give you some more information then. Mr X believes the police are working with the housing association because none of them want his “type” in the neighbourhood. Mr X does not accept that his family have genuine concern about his wellbeing. He believes they are working with his ex-wife to get him into hospital. He believes his ex-wife plans to move back into the house when he is in hospital and change the locks. Mr X believes his ex-wife is having a relationship with the housing association estate manager and they have “cooked up this plan together”. Mr X states that his ex-wife and the estate manager are members of a secret organisation “The illuminati”. He states the belief that he thinks his sister may also be involved and it’s a well-known fact that mental health services are under the control of the “illuminati”.

G1 Right – he’s given a lot more information there, I think to me it feels that he’s not well at all. I think the kind of persecutory type thoughts that he’s having are very prevalent – I would kind of what to know what he plans to do with that information, I would want to know what his next steps are, because the concerns that people are bringing up and the things that he’s saying is he going to act on anything, especially since people have said about anti-social behaviour, the neighbours and things like that the police having anti-social behaviour order I seem to remember. It doesn’t seem right to me that he has the lack of engagement with the mental health services as well that’s causing me more concerns as well as is he taking his medication, does that usually help, is that something that has changed for him, is he using cannabis, it still doesn’t really say that but I think that kind of, around medication and things like that I tend to ask for the Doctors opinions more, and around his diagnosis and things like that, it’s not my job to look at that, I see my job more about a more of a holistic way of looking at people and whether they risks are there for us to take action. What I would like to know is comparatively is this him at his worse, is leading up to something that could be quite dangerous for him or for somebody else or is this kind of him plateauing a bit or not because everybody is different. People can have persecutory thoughts and not act on them basically, is he looking after himself, is he eating like his mum says, she doesn’t think that he is. If he’s not eating or drinking properly things are going to deteriorate for him.

AB So what are your options?

G1 The options I think are around the kind of crisis services that can be offered if he was willing to engage with them. When people are not willing to engage that causes more problems, the

Doctors need to make their own decisions, they decide whether they want to make a medical recommendation or not, usually after a discussion with myself, but I've still got options after, even if both of the medical recommendations are made. So that aside, there's treatment at home with Home Based Treatment, hopefully with him engaging, so that kind of support plan in place with a longer term plan of looking at his cannabis use if he is willing to and requesting that he does engage with services, because you could put a time limit on it and still have those medical recommendations.

AB Right so what would rule that in and what would allow you to do that.

G1 What would allow me to do the Home-Based Treatment type stuff?

AB You suggested Home Based Treatment as the first option. What is it that would convince you – or how would you make the decision to go down that route?

G1 He would have to agree to it, he would have to have the capacity to agree to it as well I think but if was flat out there's no way and I felt that there was risks there for him and for other people I think you are then stuck in this idea that you've got to possibly detain him really in my view.

AB So if he didn't agree to it or didn't have the capacity did you say?

G1 No, because he's got to be able to retain that he's agreed to it basically, so I mean even people that don't retain that information you can still put services in place, the professionals who've worked in mental health know what they doing to try and help somebody engage and that opportunity has to be given to him. But it seems like that has been tried I think what was said earlier, that's an option, and it's something that we always discuss when I'm doing an assessment because it's the least restrictive in my view.

AB So if that option was ruled out what other options do you have, or what is your next option.

G1 You could leave him alone.

AB What are the circumstances in which you would do that?

G1 When I felt that the risks weren't there, when I felt that his mental health was maybe stable enough, the Doctors views are quite helpful in that as well because especially if the psychiatrist is there that knows him and is from that service or the care coordinator as well, it's around looking at what their able to do and they can come to an agreement with him. You would have to be looking at risk there, you have to look at is feasible for him, his neighbours and his family.

AB So if you had ruled out leaving him and you've ruled out supporting him at home with community services, what would your next option be?

- G1 Making the decision about the detention really, it would be a decision between a Section 2 and a Section 3, because of some many reasons if you've done them down a bit, he has relatively recently just been under a Section 3. My issue is still about the length of time since the tribunal, I'm still thinking about that.
- AB So the length of time since the tribunal would be something that would influence that decision.
- G1 Well it has to be, because you can't go against the tribunal, for example if somebody is discharged by a tribunal you can't just sit there and say well I disagree with the tribunal and detain them again. What's the point of having it, its null and void isn't it, but then if there's been a period where he has gone home and he has started using cannabis again, and he's stopped taking his medication he has stopped engaging with services which is something that he agreed to in the tribunal then that period is enough for you to say ok things have changed enough for us to say that we are going to have to look at detaining you again. But if that period's been 24 hours or something like that it's not very long. It's a difficult situation and I would probably be seeking advice to be honest to make sure that you are acting lawfully.
- AB So if it was a very short period of time you would be concerned that you were overturning a decision of the tribunal.
- G1 Yes but that has been established before I did the assessment. I've done this assessment based on probably the idea that there has been a period of time, long enough for us to be saying "ok this isn't working", things have happened in that period of time for us to say ok another assessment was needed.
- AB OK – so if that time has passed and you can now make a decision to detain somebody, you said your options were a Section 2 or a Section 3 What would the considerations there be between those 2 sections and whether you would one or the other.
- G1 I have never gone out to see somebody who is in the community that hasn't been in hospital for a while or anything like that, but he's known to services and the rest of it that you would never expect someone to turn around to say it's going to be a Section 3. I've never had that at all, it's always been a Section 2, my view is with that is that they've not just been in hospital and been assessed, even though everybody in the community who's under the mental health teams are being assessed they are not assessed under the Mental Health Act constantly, and they are not assessed as a detained patient, so that period of assessment is least restrictive, it's only 28 days. But for Mr X, he has just had a period in hospital, and it could be relatively recently. The assessment has been done; the only thing that has changed is that period at home where he's potentially started using cannabis again which he said was the problem

before, and potentially not taking his medication if that's been the case. There are those kinds of factors that would mean that the assessment has taken place, he's just been discharged from hospital relatively recently so you would probably be looking at a Section 3 for him again. I think that's what the majority of the way my thought process would probably go, the majority of the time, I think always in fact if it was that recent.

AB If it was that recent then you would be more inclined to go towards a Section 3.

G1 Yes.

AB Right ok so you make your decision to detain, what happens now?

G1 I would need to find out if they've got a bed for him, that the crux then, it's different in Older People Services but for his age I think at the moment bed situation- they are bad in the Older Peoples I think but Out of Area Beds for Older People I don't think it happens as often as it does for younger people unfortunately. I think younger people have got a short straw with that but usually you would speak to whoever's arranging the bed and find out if there's a bed available.

AB So you would be arranging a bed, and if you have a bed available what do you do then.

G1 I ring an ambulance for transport.

AB Why an ambulance.

G1 Oh hang on a minute the nearest relative needs to be consulted, the nearest relative would need to be consulted before I would be able to sign my papers so establishing that nearest relative. I think I've established it as the mother and so she would have to be consulted because she can object. So, presuming she hasn't objected and we are going ahead with it we would ring an ambulance, for the ambulance to transport Mr X to the allocated bed wherever that may be.

AB And why an ambulance.

G1 That's the procedure in (Local Authority), always go with an ambulance first in my view.

AB You would go with an ambulance because that's the procedure in (Local Authority).

G1 Yes, if I rang the police and only the police well, I wouldn't take them, but if you rang the police and only the police, they would want an ambulance to transport them anyway.

AB Right so you wouldn't transport them yourself.

G1 It's not recommended, and family are not recommended.

AB And is that established in the law or is that policy and procedure.

G1 Family is Code of Practice I believe, you have to look at the dignity of the person I do know that there have been AMHP's in the past that have used family in circumstances where it was deemed the most appropriate because of how that person felt about going into hospital, they

were more willing to go with the family, the family felt secure in doing that, it was risk assessed and agreed upon, I haven't done it. The AMHP should not take somebody in their car I believe that's law; I can't remember I would have to look that up.

AB But that's something you wouldn't, so ordinarily you would phone the ambulance and in exceptional circumstances you could consider the family. You would never do it personally, you mentioned the police, what are the circumstances in which you may consider involving the police and getting the person to hospital.

G1 The circumstances involving the police are if the ambulance crew are there and the person is refusing point blank to go, the ambulance crew would not forcibly be able to remove somebody and so the police are often called then. They have also been used when there is a risk of violence, aggression, that's when you coordinate them both together at the same time.

AB OK so Mr X gets to hospital, what is it that you are hoping that a hospital admission will achieve for Mr X.

G1 The hope is that they are able to support him to having his mental health stabilised enough for him to be able to go home and be safe in doing so, preventing him being detained again.

AB How would they achieve that?

G1 Unfortunately I think the wards rely on medication a lot, and that's an unfortunate thing. I don't know that much about working age adult's wards, but my experience largely is that they rely very very highly on medication and what I would prefer is things like psycho social interventions and assessments, those types of things that really support people and really help them to develop ways of coping before they go home. I don't think it happens that much.

AB OK – last question then, seeing this process of assessment do you experience conflict with other professionals.

G1 Yes

AB Can you give an example?

G1 Of my own practice, when something has happened.

AB Of conflict you have experienced with other professionals.

G1 I have had raised voiced arguments with ambulance crew about whether they would attend or not and have been put through to managers and the ambulance to actually get somebody seen. With the police as well, sometimes they won't attend, that's happened only once though, and I have managed to persuade them in the end and they did attend. From my point of view, I know this isn't the same for everybody else but my experience with the police has been a little better than with the ambulance. Getting Doctors to attend can be very difficult, when you know that they should be the person to go that can be very hard, when they know

the person, they've had experience of the person for years and that kind of thing that can be quite difficult because as an AMHP you know your responsibilities I think sometimes the Doctors get an easy way out, to say they are not available it's just hard. Other than that I don't think so, it can be difficult sometimes taking people on to a very busy ward when they feel that they're under pressure and it's just "are they back again" those kind of situations can be hard to cope with but, I mean largely things are resolved in my experience I don't think I've had really really difficult situations that I've heard from other AMHP's I think it's been only brief and it's been resolved, I think I've been lucky.

AB      That concludes the interview.

### 8.3 Coding

Analysis involved several stages: 1) purposeful reading of transcripts without coding, 2) coding and 3) application of an additional taxonomy (risk grids). After initially highlighting emerging themes from a small selection of transcripts (five) using colour highlighting pens, a formal coding system was developed linking initial themes to the legal requirements of the MHA. These codes were then applied to the analysis of all the transcripts (n=18).

Criteria for consideration of detention in the MHA and its associated CoP	Sub-criteria	Code
The mental disorder is of a nature, which is a diagnostic criteria or degree which refers to the acuity or manifestation of the disorder	Mental Disorder: Nature	MDN
	Mental Disorder: Degree	MDD
	Mental Disorder: Nature and/or degree	MDND
The mental disorder must also have associated risks to the person's health, safety or the protection of others, these are coded below	Interest of health	IH
	Interest of safety	IS
	Protection of others	PO
There must be a causal link between the mental disorder and the risks which is known as the causative nexus.	Causative Nexus	CN
	Least Restrictive and Maximising Independence	LR

There are also five core principles that the AMHP needs to consider throughout the process of decision-making. These are explained in more detail in the introduction.	Empowerment and Involvement	EI
	Respect and Dignity	RD
	Purpose and Effectiveness	PE
	Efficiency and Equity	EE

This stage of the analysis led to the identification of main themes (described below in the thematic grid) but in order to fully capture sub-themes, it was felt necessary to develop three further grids as illustrated in the following sections.

## 8.4 Thematic Grid

Interview XXX

Risk Themes	Quotation	Comments
Actuarial		
Forensic/Historical	<p>Being mindful I suppose about risks in different ways, risk to that individual, risks to others, looking at past historical behaviours, substance misuse and whether you're going to need support from police perhaps if there's been a history of aggression.</p> <p>I think in terms of risk in terms of family's knowledge of him, because the systemic assessment is obviously about family's views, opinions and beliefs. They know that individual well, it sounds though that this chaps quite distressed, it sounds that his behaviours affecting the family, the system they are worried, you know so I think it would be appropriate to at that point you know when you have collated information in terms of his history, collating information from the community mental health team. There seems to be a pattern of kind of relapse indicators that his wife has clearly identified. Yes I think it would be about mobilising a mental health act assessment at that point.</p>	
Current/Clinical	<p>(B)I think in terms of risk in terms of family's knowledge of him, because the systemic assessment is obviously about family's views, opinions and beliefs. They know that individual well, it sounds though that this chaps quite distressed, it sounds that his behaviours affecting the family, the system they are worried, you know so I think it would be appropriate to at that point you know when you have collated information in terms of his history, collating information from the community mental health team. There seems to be a pattern of kind of relapse indicators that his wife has clearly identified. Yes I think it would be about mobilising a mental health act assessment at that point.</p>	

	<p>it depends on circumstances; I think for me it would depend on the level of risk, that person is posing to themselves and others. And it would be a very kind systemic perspective as well because you know it's not just about our crisis team but just how the impact that that person having a mental disorder going to have his kids for instance, if they are staying at weekends. Is the other kind of informal support around that person, I think capacity as well I think mental capacity comes into it, I think it's a wonderful empowering piece of legislation because it does enable people to take positive risks and even if people have a mental disorder doesn't mean to say they have to haven't got mental capacity to make choices about the decisions about what they want because. You know when it's working when that person doesn't want to go into hospital – I think for me that am an opportunity you know to work with them in a least restrictive stuff. In terms of providing some support that's going to be realistically feasible really to support that person and manage their risks. It does happen with crisis team often 136 assessments, so a lot of assessments can end up with crisis team and Intensive Home Based Treatment team and avert a hospital admission really.</p>	
Necessity of a MHA assessment	<p>I think it's clarifying because sometimes you can get a request for an assessment but it's actually a mental health assessment rather than a Mental Health Act assessment and that can depend on what the AMHP's role is to consider and whether an assessment ought to take place – you don't have to kind of act unthinkingly to every referral that you get, there is I suppose a system risk assessment with information that you getting and piecing together – how you need to respond to that referral itself.</p> <p>it's about the kind of I suppose ascertaining what's actually been asked for – I mean the question I have and always have in mind is because people do ask and I think you can act unthinkingly the question I have in mind is does that person need to be in hospital for their wellbeing, for their safety for a risk assessment. Potentially</p>	

	<p>they will be deprived of their liberty – that is the question that would kind of trigger a mental health act assessment for me.</p> <p>I don't think it's about time, perhaps I think it's perhaps about the presentation you know. If someone was discharged from a tribunal then the following week there was a request for a mental health act assessment you would be thinking what is different, what information hadn't the tribunal had – if its further down the line I guess that perhaps would be less relevant and it would be about assessing I suppose risks to that person, their welfare, their wellbeing, risk to others you know, I suppose your thoughts would be different as time went on because otherwise it wouldn't make sense. If someone had been discharged from a tribunal and then 6 months down the line their lifestyle could be completely different. There could be loads of stuff going on, so you wouldn't be necessarily thinking well though they were discharged from a tribunal 6 months ago – I suppose if it had have been kind of recent period then you know – because it's about deprivation its it, it's about somebody's detention and freedom when in order to kind of act in terms of the AMHP assessment and somebody has been discharged from a tribunal there has to be something very significant in their thinking in order to look at whether that person is a risk assessment or a trip in hospital.</p> <p>(b)</p> <p>I think in terms of risk in terms of family's knowledge of him, because the systemic assessment is obviously about family's views, opinions and beliefs. They know that individual well, it sounds though that this chaps quite distressed, it sounds that his behaviours affecting the family, the system they are worried, you know so I think it would be appropriate to at that point you know when you have collated information in terms of his history, collating information from the community mental health team. There seems to be a pattern of kind of relapse indicators that his wife has clearly identified. Yes I think it would be</p>	
--	--	--

	<p>about mobilising a mental health act assessment at that point.</p> <p>I mean there's a contradiction isn't there between this chap and his needs and resources isn't there you know. I think for me it's about being reflective here or being reactive and if there's elevating risks I think you have to kind of go ahead with an assessment and this is one of the things we have – its nationwide isn't it, you know this thing about waiting for a bed. It kind of putting resources before that individual isn't it you know – I think if there has been a history of violence I mean that's quite clear this kind of historical presentation – there would be potentially thinking about assistance from our police colleagues. I wouldn't feel comfortable in kind of just waiting it could be days couldn't it. It could be days for this chap and he could abscond, he sounds distressed, family are concerned so I think you would have to kind of act on what you've got you know. That's just the thing about resources it's a difficult one isn't it.</p>	
Urgency of an assessment	<p>It's kind of getting the information together and depending on what you've got with you can be more reflective than reactive. It's obvious if those risks are quite escalated I think you can act sooner rather than later rather than sitting back and getting as much information as possible.</p>	
How to undertake assessment	<p>I think I would be speaking to his wife, as priority if I could, and getting her views and opinions and informing her of what's intending to happen. Ask if in terms of if she feels there is going to be a risk to individuals, practitioners and things like that.</p> <p>There is this thing where carer control and it kind of tapers up, you can't just leave that and say fair enough and walk away, something needs to happen in terms of that. I have found sometimes that an authority figure such as the police, if the police were there that they can change a situation, it is about coercive control you know. As you kind of think about it I think sometimes if</p>	

	<p>there are police there and there has been risks it can actually be very containing you know and enable that person to co-operate really to some extent. It's not ideal but I think – it's that care and control isn't it you've to take more kind of decision making because you know failing that then you are looking at a warrant aren't you in terms of entering the premises and things you know. If he's not going to allow access – I don't think at that stage you can just of leave it you - it has to be seen through. We have got to this point for a reason.</p>	
Deciding outcome of an assessment	<p>(b) it depends on circumstances; I think for me it would depend on the level of risk, that person is posing to themselves and others. And it would be a very kind systemic perspective as well because you know it's not just about our crisis team but just how the impact that that person having a mental disorder going to have his kids for instance, if they are staying at weekends. Is the other kind of informal support around that person, I think capacity as well I think mental capacity comes into it, I think it's a wonderful empowering piece of legislation because it does enable people to take positive risks and even if people have a mental disorder doesn't mean to say they have to haven't got mental capacity to make choices about the decisions about what they want because. You know when it's working when that person doesn't want to go into hospital – I think for me that am an opportunity you know to work with them in a least restrictive stuff. In terms of providing some support that's going to be realistically feasible really to support that person and manage their risks. It does happen with crisis team often 136 assessments, so a lot of assessments can end up with crisis team and Intensive Home Based Treatment team and avert a hospital admission really.</p> <p>I mean every assessment is different, I think you know sometimes I think things can change and it's very hard to kind of think about it in a sort of cold, if you are talking about the process in terms of conveyance it's the AMHP's role – they explain to that</p>	

	<p>person what's going off and what decisions have been made and how you would convey. There's previous information about assaulting a health care practitioner that's a real kind of risk. So would be thinking about safety of that individual, safety of assessing practitioners – In this scenario police would probably be out there, I would suggest ambulance really because. Conveyance in a police car and conveyance in an ambulance can be a very different kind of experience for any one of us can't it you know. Especially if he is paranoid it can feed into that that he's being punished and just add to the distress. The first port of call would be an ambulance.</p>	
Difference of opinion:		
Other practitioners		
Doctors	<p>, I think sometimes you get this sense well I have actually done a good job here, you know bringing that kind of social perspective to some bare, I think Doctors can be very risk averse and it can be depending time of day, I mean when I been to places where an applications have actually been made out, which is fair enough that the person been interviewed by myself and another doctor and its completely kind of different it's not just about the degree and stuff but yes, so I have had situations where I've gone back to one of the Section 12 Doctors and said we are not going to detain on this occasion, he's engaging with Crisis team, co-operating with mental health team, there is risks there but the person's capacitous, they are not that elevated that you must act and then you get into kind of wrangles well actually there is risk to this individual this that another but you kind of – there is positive risk taking really, you know. I think that's a major part of role because you know, otherwise I think it can be a blinkered sort of medical model approach in terms of assessment</p>	
Family	<p>. You often get that can't you – I think often with family it could be a win win situation where a lot of distress can be met by a lot of anxiety and they just want something done and can be quite desperate</p>	
Service User		

Police	it has happened where people become physically violent you know. You get these scenarios can't you in terms of police won't come until ambulance and ambulance won't come until police – ideally but its mobilised if the kind of risk threshold is very rare but they are both kind of on standby aren't they you know and then you've got the delays with ambulance and if things worked how they should do but obviously with resources and things you don't know. But yes I think ambulance.		
Ambulance	(b) it has happened where people become physically violent you know. You get these scenarios can't you in terms of police won't come until ambulance and ambulance won't come until police – ideally but its mobilised if the kind of risk threshold is very rare but they are both kind of on standby aren't they you know and then you've got the delays with ambulance and if things worked how they should do but obviously with resources and things you don't know. But yes I think ambulance.		
Others			
	Police		
	Ambulance		
	Others		

## 8.5 Evidence Grids

### 8.5.1 Risk Grid/Risks Explored in a MHA

Risks Explored in a Mental Health Assessment		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)
Historical Risks; Questions that were important to the AMHP about the person's past	Mental health history	<p>Is the person known to services? (MDND)</p> <p>Is there an established diagnosis and what are the symptoms? (MDND)</p> <p>Previous pattern of mental health deterioration (prognosis). (MDND)</p> <p>Is this a relapse signature indicating return of prior mental health problems? (MDND)</p> <p>Have there been previous admissions (MDND)</p> <p>Does the person engage with services and accept help? (MDND) (EI)</p> <p>Previous response to treatment or support (MDND)</p>
		<p>Self</p> <p>Has the person previously expressed suicidal thoughts and did they act on those thoughts? (IH) (IS)</p> <p>History of self-harm (IH) (IS)</p>

	Has there been risk to self or others in the past arising from their mental health? (IH) (IS)	<p>Is there a history of self-neglect? (IH) (IS)</p> <p>Risk of retaliatory behaviour (IS)</p> <p>Has the person's mental health negatively impacted on family members or family relationships (PO)</p> <p>History of risk-taking behaviour (IH) (IS)</p>
		<p>Risk to others</p> <p>Person's history of violence or aggression (PO)</p> <p>Has the person's mental health negatively impacted on family members or family relationships (PO)</p>
	Additional Considerations	<p>Does the person have a history of substance misuse or had episodes of drug induced mental health problems? (MDND)</p> <p>History of acting on delusional/paranoid beliefs (MDND) (IH) (IS) (PO) (CN)</p> <p>Context of historical risks (CN) (LR)</p> <p>Who is raising concerns about the person and how well do they know them (History of the referrer).</p> <p>History of criminal or deviant behaviour</p>

	Risks associated with assessment	<p>Person's beliefs relating to being assessed or going to hospital (MDND)</p> <p>Previous behaviour during assessment (MDND) (IS) (PO)</p> <p>Impact of police presence (LR) (RD)</p> <p>Impact of presence of people who know the person (LR) (EI)</p> <p>Risk of absconding</p>

Risks Explored in a Mental Health Assessment		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)
Current Perceived Risks; Is this risk presenting itself as an immediate problem?	What is being requested and why? (PE) (LR)	<p>What is being requested by the referrer? (PE) (LR)</p> <p>What is the practitioner actually asking for mental health or MHAA? (PE) (LR)</p> <p>What is it about the person's behaviour that is causing concern to others? (PE) (LR) (IH) (IS) (PO)</p> <p>What is their motivation for the request? (PE)</p> <p>Are concerns substantiated? (PE)</p> <p>Who is concerned, how well do they know the person? (PE)</p>

		Do they or are they likely to meet detention criteria? (PE) (LR)
	What is the context of the current risks	<p>Are there any current stressors? (MDND) (CN)</p> <p>Have there been significant recent life events? (MDND) (CN)</p> <p>Are family relations good or disturbed? (MDND) (CN) (LR)</p> <p>Are they experiencing or involved in Anti-social behaviour? (PO)</p> <p>Is behaviour caused by mental illness or is it deviant/criminal? (CN)</p> <p>Is there evidence of current substance misuse? (MDND) (IH) (IS) (PO)</p> <p>Is there evidence of paranoid beliefs being grounded in reality/risk of misinterpretation? (MDND) (CN) (LR) (PE)</p>
	Current Mental State	<p>Is there evidence of psychosis? (MDND)</p> <p>Are they experiencing or acting on delusional/paranoid beliefs? (MDND) (CN) (IH) (IS) (PO) (CN)</p>

		<p>What thoughts is the person expressing? (MDND) (CN) (IH) (IS) (PO) (CN)</p> <p>Are they acting on delusional beliefs? (MDND) (CN) (IH) (IS) (PO) (CN)</p> <p>Do they have negative beliefs or paranoid thoughts about others? (MDND) (CN) (PO)</p> <p>Is this a relapse signature indicating return of prior mental health problems? (MDND)</p> <p>Is the person expressing suicidal thoughts? (IH) (IS)</p> <p>Is the person self-neglecting? (IH) (IS)</p> <p>Is there sleep disturbance or reduced appetite? (MDND) (IH)</p> <p>Do they have “insight” or concur with the belief of others that they are mentally unwell? (MDND) (CN) (EI)</p>
	Is there currently risk to self or others?	
	Self	Content of beliefs and what they could lead to? (MDND) (CN) (IH) (IS) (PO) (CN)

		<p>Has the person expressed suicidal intent or made a plan? (IS)</p> <p>Has the person self –harmed? (IS)</p> <p>Could this lead to risk of retaliatory behaviour? (IS)</p>
	Risk to others	<p>Content of beliefs and what they could lead to? (MDND)(PO) (CN)</p> <p>Are they violent or aggressive/Threatening violence or aggression? (PO)</p> <p>Hostility to others/verbal aggression (PO)</p> <p>Presence of children (PO)</p> <p>What impact is the person’s mental health having on family or carers (particularly children) or family relationships? (PO)</p>
	Other considerations	<p>Other considerations</p> <p>Are the perceived risks immediate? (LR)</p> <p>Is the person engaging in risky behaviour? (IH) (IS) (PO)</p> <p>Is there evidence of impulsive behaviour? (IH) (IS) (PO)</p> <p>Do they have “insight” or concur with the belief of others that they are mentally unwell? (MDND) (CN) (EI) (LR)</p>

		<p>Are they willing to give guarantees about their own safety or the safety of others? (LR) (EI) (IH) (IS) (PO)</p> <p>Is the person currently engaging with services? (LR) (EI) (PE)</p> <p>Is there a willingness to engage with services? (LR) (EI) (PE)</p> <p>What is the person saying to others about possible support/treatment or hospital admission? (LR) (EI)</p> <p>Is there evidence of fluctuating capacity or capacity to consent? (EI) (LR)</p> <p>Is there evidence of current substance misuse? (CN) (IS) (PO)</p> <p>Has the person been taking their medication? (MDND) (IH)</p> <p>Are less restrictive alternatives viable? (LR) (EI) (PE) (IH) (IS) (PO)</p> <p>What are the person's current care and support arrangements? (LR)</p> <p>Can the person function despite their mental illness? (MDND) (LR)</p>
--	--	---

		<p>Does the person live alone, and do they have suitable accommodation? (IH) (IS)</p> <p>Is there a risk they will lose their accommodation? (IH)</p> <p>What is the person's physical presentation? (MDND)</p> <p>Is the person looking after their physical health? (IH)</p> <p>Is the person socially isolated?</p>
	Risks associated with assessment	<p>Is the person currently detained or in a safe place/ Current MHA status? (EE)</p> <p>What is the person saying to others about possible support/treatment or hospital admission? (EI)</p> <p>What is the current bed availability/ Police availability? (EE)</p> <p>What will the impact of having police present have on the person's dignity, safety or assessment outcome? (LR) (RD)</p> <p>What impact will having family present or people who know the person? (RD) (LR)</p> <p>How might these factors increase risk of detention or risk of absconding? (LR) (RD) (IS)</p>

Risks Explored in a Mental Health Assessment		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)
Established risks and future Risks: What factors lead to decision to detain.	They meet the detention criteria under MHA	
	The perceived risks to self or others unmanageable outside of hospital (LR)	
	Risk to Self (PO)	<p>The person is engaging in risky behaviour associated with their mental health symptoms (IH) (IS) (PO)</p> <p>There is a risk of someone retaliating to their behaviour and their behaviour is a product of mental illness (IS) (CN)</p> <p>The person expressing suicidal thoughts, but more emphasis is on the person's expressed suicidal intent or suicide plan (IS)</p> <p>The person has self –harmed and the intention behind the self-harm was not clear. (IS) (IH)</p> <p>There is evidence of impulsive behaviour associated with mental illness (MDND) (IS) (PO)</p>

	<p>Risk to others (PO)</p> <p>They are violent or aggressive/threatening violence or aggression/hostile to others and this can be linked to their mental health symptoms. (PO) (CN)</p> <p>The thoughts the person is expressing are negative beliefs or paranoid thoughts about others, or the person is experiencing intrusive thoughts/voices indicating they should act in a way harmful to themselves or others. Their expressed beliefs could also lead to retaliatory behaviour by others. (MDND) (IS) (PO)</p> <p>There is evidence of psychosis or psychotic beliefs and perceived risks to self or others are linked to delusional or paranoid beliefs. (CN)</p> <p>The capacity of others to continue caring for the person and the possible negative impact this will have on them and vulnerable others (including children). (PO) (RD)</p> <p>The person presentation is considered to be a relapse</p>
--	---

		<p>indicating return of prior mental health problems and previous indicates lack of community engagement and eventual admission. (MDND) (CN) (EI)</p>
	Person's engagement	<p>They are not willing or able to give guarantees about their own safety or the safety of others (EI) (IS) (PO)</p> <p>The person is not agreeing to engage with services or they are agreeing but are unlikely to do so (EI) (MDND) (LR)</p> <p>The person is not willing to restart their medication or engage with treatment (MDND) (LR) (EI)</p> <p>They are assessed as lacking "insight" or do not concur with the belief of others that they are mentally unwell. (MDND) (EI)</p> <p>The person is assessed as lacking the capacity to consent to care and support outside hospital or it is asessed that their capacity is fluctuating (LR) (EI)</p>

		<p>Informal admission is not legal i.e. the person lacks capacity or there is evidence of fluctuating capacity. (LR) (EI)</p> <p>There is evidence of current substance misuse and a refusal to address their substance misuse. (CN) (EI)</p>
	Future Risks	<p>There is a risk of future deterioration in the person's mental health if the person is not treated/contained. (IH)</p> <p>There may be negative social consequences such as eviction or breakdown in relationships if the person's behaviour is not contained.</p> <p>There is a risk to the person's physical health due the person's mental health either through self-neglect or delusional beliefs. (IH) (CN) (MDND)</p> <p>The risks, although affected by social/family circumstances, are presented through symptoms of mental ill health</p>

		<p>and the risks are too immediate or not resolvable in the short term. (MDND)</p> <p>Decisions about undertaking an assessment or delaying an application are sometimes made due to lack of resources and possibility that the assessment may increase risks of harm to self or others (LR) (EE)</p>

### 8.5.2 Conflicts Grid/Conflicts Experienced in a MHA

The grid below collates the responses from the AMHPs about what the conflicts of opinion they experience with others during the assessment process. These are coded in relation to the MHA as above.

Conflicts Experienced in a Mental Health Assessment		
Overarching Category	Areas explored (plus codes)	Specific questions (plus codes)
Conflicts/Differences of opinion that arise during assessment.	Other Health Care Professionals	<p>Conflict with others throughout the process relating to difference of opinion:</p> <p>Community teams about necessity of MHA (LR)</p> <p>Other mental health services about less restrictive alternatives to assessment or detention such proactive engagement/HBT etc. (LR)</p> <p>Other agencies or professionals not understanding the law</p> <p>Other health colleagues being too quick to consider detention and not considering the impact of someone being deprived of their liberty (LR)</p> <p>Conflict with other service about support for the assessment or admission:</p>

		<p>Police, Ambulance, bed managers, HBT (EE)</p> <p>Conflict with inpatient staff who do not believe admission is appropriate (PE) (LR) (EE)</p>
	Family/carers	<p>Difference of opinion with family and carers about levels of risk. (IH) (IS) (PO)</p> <p>Difference of opinion with Nearest Relative who does not agree with admission. (IH) (IS) (PO)</p>
	Doctors	<p>Conflict is both ways, sometimes Doctors see risk and we do not sometimes we believe there is a risk and Doctors do not see person as meeting criteria for detention. (MCMD) (IH) (IS) (PO) (LR)</p> <p>Conflict is sometimes between the Doctors, sometimes it is one Dr vs. another Dr and the AMHP</p> <p>Doctors viewed as more risk averse (LR)</p> <p>Belief that often AMHPs have more contextual information</p>

		<p>and would prefer to follow less restrictive options but Doctors are more medically focused on the cause of symptoms. (MCND) (LR)</p> <p>Belief that Doctors tend to have a more medicalised approach than AMHPs (MDND)</p> <p>Some Doctors have a blinkered medical view (MDND)</p> <p>Doctors minimise social perspectives (MDND)</p> <p>Difference of opinion about causes of relapse Doctors tend to focus on person not taking medication (CN)</p> <p>Difference of opinion about diagnosis where the question of personality disorder is raised (MDND)</p> <p>Difference of approach from Doctors regarding the question of capacity.</p> <p>AMHPs view their approach is closer to principles of MCA, such as the right to make unwise decisions. (EI)</p>
--	--	---

		<p>Doctors often have made a recommendation before second Dr and AMHP have seen the person (LR)</p> <p>Difference of opinion about purpose of admission Doctors more focused on restarting or initiating medication. (PE)</p> <p>Difference of opinion about which section is most appropriate and least restrictive (LR)</p> <p>Conflict when Doctors have pre-determined the outcome such as a CTO and the AMHP is not in agreement and unwilling to sign an application etc. (LR)</p>
	Personally Conflicted	<p>AMHP describes greater conflict with themselves when they are out of their comfort zone and assessing people from service user groups they are not familiar with (MDND) (LR) (EI) (RD) (CN)</p> <p>Conflict of convincing others of a course of action when they are not sure themselves. (LR) (PE)</p> <p>Conflict with self about condemning people to be a lifetime psychiatric patient (MDND) (LR)</p>

		<p>Conflict with self about efficacy of admission and dominance of medical model in psychiatric hospital (MDND)</p> <p>Conflict with self about whether the decision to detain or not was the right one. (LR)</p> <p>Conflict with self that person was detained because less restrictive alternatives were not available. (LR) (EE)</p> <p>Conflict when the admission is clearly due to lack of resources and could be avoided if an alternative resource was available. (EE) (LR)</p>
--	--	--

### 8.5.3 Expectations Grid/ Expectations Expressed about a MHA Assessment Outcome

The grid below collates all the responses from the AMHPs about what they expected an admission to achieve for Mr X. Again, they have been coded against the principles of the MHA and the criteria for detention. As above.

Expectations explored in a Mental Health Assessment		
Overarching Risk Category	Areas explored (plus codes)	Specific questions (plus codes)
What does the AMHP expect the detention to achieve	Assessment	<p>To continue the process of assessment (MDND) (LR)</p> <p>To ensure a thorough assessment in a safe environment (IH) (IS) (PO)</p> <p>Immediate assessment of how unwell the person is (MDND)</p> <p>To eliminate factors other than mental illness (such as substance misuse as sole causative factor) (MDND)</p> <p>Establish true nature or content of patient's behaviour (MDND)</p> <p>Time to consider true picture of social relationships</p> <p>To confirm if symptoms are consistent with previous diagnosis or if this is a new episode/presentation of mental illness (MDND) (CN)</p> <p>Possible causes of the person's episode of mental illness (MDND)</p> <p>To confirm if not taking medication has caused relapse (MDND)</p>

		<p>Consider appropriate treatment including medication (PE)</p> <p>Is this a relapse of a previously diagnosed condition or a new presentation? (MDND)</p> <p>Assess his level of personal functioning with everyday living skills.</p>
	Manage Risk	<p>Safe environment that can manage risk to self or others (IH) (IS) (PO)</p> <p>To manage distress in a contained environment (IH) (IS)</p> <p>To provide a safer environment to manage suicide risks. (IS)</p> <p>To provide a contained environment (IS) (PO)</p>
	Treatment	<p>Re-establish medication (MDND)</p> <p>Time out to re-stabilise the person's mood (MDND)</p> <p>A safe environment that can lead to a reduction in distress for the person (IH)</p> <p>Opportunity for the person to develop insight (EI)</p> <p>To receive psychosocial interventions although feeling they are not necessarily available. (MDND)</p>

	Review	<p>Opportunity for the person to develop insight (EI)</p> <p>Enable the patient to review themselves what caused them to become unwell (EI)</p> <p>To enable the patient to review their family relationships and assess what might have gone wrong (EI)</p> <p>Patient to learn the possible relationship between substance misuse and mental illness (EI)</p> <p>Period of assessment of his emotional and social needs including self-reflection and prioritisation (EI)</p> <p>Find out why he does not want medication/treatment and find out if there is anything that is more acceptable to him (EI)</p> <p>To give him the opportunity to speak to mental health professionals and work through his current difficulties (EI)</p> <p>Give the person time to reconnect with their family and other social relationships (EI)</p> <p>Give the person time to reconnect with themselves as they often feel fragmented. (EI)</p>
--	--------	---

		Consider appropriate treatment including medication (MDND)
	Plan	<p>To allow time for the development of a robust discharge plan (LR) (IH) (IS) (PO) (MDND)</p> <p>Opportunity for the person to state what their wishes would be (EI)</p> <p>Make plans to avoid future relapses (MDND)</p> <p>To establish a treatment plan for discharge (MDND)</p> <p>Rebuild support networks (EI)</p> <p>Time to establish/re-establish community support (EI) (LR)</p>

## 8.6 Research Invitation



### Invitation to participate in research

Dear Colleague,

I am currently undertaking research into decision-making by Approved Mental Health Professionals and would like to invite you to participate. The title of the study is: An Exploration of the Interplay between, Beliefs, Legislation and Situational Factors that shape Decision-making by Approved Mental Health Professionals. I will be interviewing individual Approved Mental Health Professionals employed by (Local Authority) Council. The interviews will take about an hour and fifteen minutes. I will be presenting a fictional case scenario and will be asking for your responses to various aspects of the scenario. Interviews will be audio-recorded and transcribed.

Before undertaking the interview, you will receive information about anonymity and confidentiality, and you will be free to withdraw consent at any time. If you would be interested in participating, please contact me using the contact details below.

Regards

Andy Brammer

PT Lecturer in Social Work and PhD Researcher

## 8.7 Information Sheet Interviews



An Exploration of the Interplay between, Beliefs, Legislation and Situational Factors that shape Decision-making by Approved Mental Health Professionals

---

### INFORMATION SHEET

You are being invited to take part in the above study, which is concerned the interplay between beliefs, legislation and situational factors that shape decision-making by Approved Mental Health Professionals. Before you decide to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

#### **What is the study about?**

The purpose of this study is to find out what are the factors that affect Approved Mental Health Professionals decision-making when considering assessments under the Mental Health Act 1983 (Amended 2007)

#### **Why have I been approached?**

You have been asked to participate because you are an Approved Mental Health Professional who is approved by (Local Authority) Council and currently undertaking assessments on their behalf.

#### **Do I have to take part?**

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your future progression or access to training opportunities with (Local Authority) Council.

**What will I need to do?**

If you agree to take part in the research, you will be asked to take part in a semi-structured interview. You will be presented with a fictitious scenario relating to an MHAA. The relevant information will be given to you in stages and at each stage you will be invited to contribute your thoughts and reasons on the decisions you need to make. The interviews will take approximately 1 hour and 15 minutes.

**Will my identity be disclosed?**

All information disclosed within the interview will be kept confidential, except where legal obligations would necessitate disclosure by the researchers to appropriate personnel.

**What will happen to the information?**

All information collected from you during this research will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. The interviews will be audio-recorded and transcribed, all digital information will be password protected and names will be changed in the transcriptions to ensure anonymity.

**Who can I contact for further information?**

If you require any further information about the research, please contact me on:

Name Andy Brammer

PT Lecturer in Social Work and PhD Researcher

E-mail [a.brammer@hud.ac.uk](mailto:a.brammer@hud.ac.uk)

Telephone 07894++++++

The research supervisor is Dr Rosemary Rae at the University of Huddersfield. E mail [r.rae@hud.ac.uk](mailto:r.rae@hud.ac.uk)

## 8.8 Information Sheet Focus group



An Exploration of the Interplay between, Beliefs, Legislation and Situational Factors that shape Decision-making by Approved Mental Health Professionals

---

### INFORMATION SHEET

You are being invited to take part in the above study, which is concerned with the interplay between, beliefs, legislation and situational factors that shape decision-making by Approved Mental Health Professionals. Before you decide to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

#### **What is the study about?**

The purpose of this study is to find out what are the factors that affect Approved Mental Health Professionals decision-making when considering assessments under the Mental Health Act 1983 (Amended 2007)

#### **Why have I been approached?**

You have been asked to participate because you are an Approved Mental Health Professional who is approved by (Local Authority) Council and currently undertaking assessments on their behalf.

#### **Do I have to take part?**

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time and without giving a reason. A decision to

withdraw at any time, or a decision not to take part, will not affect your future progression or access to training opportunities with (Local Authority) Council.

**What will I need to do?**

If you agree to take part in the research, you will be asked to take part in a Focus Group. Your group will be presented with a question and supplementary questions. The discussion will be recorded and later transcribed.

**Will my identity be disclosed?**

All information disclosed within the interview will be kept confidential, except where legal obligations would necessitate disclosure by the researcher to appropriate personnel.

**What will happen to the information?**

All information collected from you during this research will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. The interviews will be audio-recorded and transcribed, all digital information will be password protected and names will be changed in the transcriptions to ensure anonymity.

**Who can I contact for further information?**

If you require any further information about the research, please contact me on:

Andy Brammer

PT Lecturer in Social Work and PhD Researcher

E-mail [a.brammer@hud.ac.uk](mailto:a.brammer@hud.ac.uk)

Telephone 07894++++++

This research is being undertaken as part of a PhD at the University of Huddersfield. The research supervisor is Dr Rosemary Rae at the University of Huddersfield. Email [r.rae@hud.ac.uk](mailto:r.rae@hud.ac.uk)

## 8.9 Consent



### CONSENT FORM

**Title of Research Project:** An Exploration of the Interplay between, Beliefs, Legislation and Situational Factors that shape Decision-making by Approved Mental Health Professionals

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research ☐

I consent to taking part in it

☐

I understand that I have the right to withdraw from the research at any time ☐

without giving any reason

I give permission for my words to be quoted (by use of pseudonym) ☐

I understand that the information collected will be kept in secure conditions ☐

for a period of five years at the University of Huddersfield

I understand that no person other than the researcher will have access to the information provided



I understand that my identity will be protected by the use of pseudonym in the

report and that no written information that could lead to my being identified will

be included in any report.

If you are satisfied that you understand the information and are happy to take part in this project, please put a tick in the box aligned to each sentence and print and sign below.

Signature of Participant:	Signature of Researcher:
Print:	Print:
Date:	Date:

(one copy to be retained by Participant / one copy to be retained by Researcher) Andy Brammer PT Lecturer in Social Work and PhD Researcher. Research Supervisor is Dr Rosemary Rae at the University of Huddersfield. E mail r.rae@hud.ac.uk

### **8.10 Permission**

Permission to undertake the research was granted by the Director of Public Health for the local authority concerned. The full email conversation and written permission is available if requested.

### **8.11 Ethical approval**

I have received ethical approval from the social research ethics panel at the University of Huddersfield. Following this I have received permission from (Local Authority) Council to have access to the AMHPs that they employ. Permission to interview AMHPs from other local authorities will be sought prior to any field research which may also require resubmission to the University for ethical approval.

## 9. REFERENCES

- ADASS. (2018). AMHPS, Mental Health Act Assessments and the Mental Health Social Care Workforce.
- Allen, N. (2010). The Bournemouth Gap (As Amended?). *Medical law review*, 18(1), 78-85. doi:10.1093/medlaw/fwq005
- Allen, N. (2013). The right to life in a suicidal state. *International journal of law and psychiatry*, 36(5-6), 350-357 <https://doi.org/10.1016/j.ijlp.2013.09.002>
- Argyris, C., & Schon, D. A. (1974). *Theory in practice: Increasing professional effectiveness*. Jossey-bass.
- Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology*, 8(1), 19-32. ISSN 1364-5579
- Armstrong, R., Hall, B. J., Doyle, J., & Waters, E. (2011). 'Scoping the scope' of a Cochrane review. *Journal of public health*, 33(1), 147-150. <https://doi.org/10.1093/pubmed/fdr015>
- Babbie, E., & Rubin, A. (1997). *Research Methods for Social Work*. London: Thomson Learning.
- Barter, C., & Renold, E. (1999). The use of vignettes in qualitative research. *Social research update*, 25(9), 1-6.
- Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, 13(4), 544-559.
- Bolker, J. (1998). *Writing your dissertation in fifteen minutes a day: A guide to starting, revising, and finishing your Doctoral Thesis*. (Bellingham: Owl Books).
- Bracken, P., & Thomas, P. (2010). From Szasz to Foucault: On the role of critical psychiatry. *Philosophy, Psychiatry, & Psychology*, 17(3), 219–228, 279–280. <https://doi.org/10.1353/ppp.2010.0007>
- Brannen, J., & Pattman, R. (2005). Work-family matters in the workplace: the use of focus groups in a study of a UK social services department. *Qualitative research*, 5(4), 523–542. <https://doi.org/10.1177/1468794105059508>
- Bressington, D. T., Wells, H., & Graham, M. (2011). A concept mapping exploration of social workers' and mental health nurses' understanding of the role of the Approved Mental Health Professional. *Nurse Education Today*, 31(6), 564-570. <https://doi.org/10.1016/j.nedt.2010.10.034>
- Brown, R. (2019). *The Approved Mental Health Professional's Guide to Mental Health Law*. Learning Matters.
- Bryman, A. (2016). *Social research methods*. Oxford university press.

Buckland, R. (2014). The decision by approved mental health professionals to use compulsory powers under the Mental Health Act 1983: A Foucauldian discourse analysis. *The British Journal of Social Work*, 46(1), 46-62.

Burr, V. (2015). *Social Constructionism* (Third edition.). London, UK: Taylor & Francis.

Campbell, J. (2010). Deciding to Detain: The Use of Compulsory Mental Health Law by UK Social Workers. *British Journal of Social Work*, 40(1), 328–334. <https://doi.org/10.1093/bjsw/bcp121>

Campbell, J., & Davidson, G., (2017) Understanding risk and coercion in the use of community based mental health laws. In Stanford, S., Sharland, E., Heller, N. R., & Warner, J. (2017). *Beyond the risk paradigm in mental health policy and practice*. (pp 17-27) Macmillan International Higher Education.

Care Quality Commission (2014). Monitoring the Mental Health Act in 2012/2013 (Report)  
Retrieved from:

[https://www.cqc.org.uk/sites/default/files/documents/cqc\\_mentalhealth\\_2012\\_13\\_07\\_update.pdf](https://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf)

Care Quality Commission (2018). Mental Health Act: The rise in the use of the MHA 83 (2007) to detain people in England (Report) Retrieved from

[https://www.cqc.org.uk/sites/default/files/20180123\\_mhadetentions\\_report.pdf](https://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf)

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., & Barlow, S. (2017). Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations*, 20(3), 471–483.

<https://doi.org/10.1111/hex.12474>

Cohen, B. (2016). *Psychiatric Hegemony: A Marxist Theory of Mental Illness*. Springer.

Daudt, H. M., van Mossel, C., & Scott, S. J. (2013). Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. *BMC medical research methodology*, 13(1), 48.

<https://doi.org/10.1186/1471-2288-13-48>

Davidson, G., & Campbell, J. (2010). An audit of assessment and reporting by Approved Social Workers (ASWs). *British Journal of Social Work*, 40(5), 1609-1627.

<https://doi.org/10.1093/bjsw/bcp060>

Denscombe, M. (2014). *The good research guide: for small-scale social research projects*. McGraw-Hill Education (UK).

Denvall, V. (2008). Evidence in Action: evidence-based decision-making in social work. *European Journal of Social Work* 11:1 29-42

Department of Health (2015). Code of Practice, the Mental Health 1983, The Stationery Office, Norwich. Retrieved from:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/435512/MHA\\_Code\\_of\\_Practice.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)

Department of Health (2013). Post-legislative Scrutiny of the Mental Health Act 2007: Response to the Report of the Health Committee of the House of Commons, (Report), The Stationery Office, London. Retrieved from:

<https://publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf>

Edwards, A., & Talbot, R. (1994). *The Hard-Pressed Researcher; a Research Book for the Caring Professions*. Buckingham: Longman Group Ltd.

Ferguson, I. (2017). *Politics of the mind: Marxism and mental distress*. Bookmarks Publications.

Ferns, P. (2005). Finding a Way Forward: A Black Perspective on Social Approaches to Mental health. In Tew, J. (2005). *Social Perspectives in Mental Health: Developing social models to understand and work with mental distress*, London: Jessica Kingsley Publishers.

Fook, J., & Askerland, G. (2006). The 'critical' in critical reflection. In White, S., Fook, J., & Gardner, F. (2006). *Critical reflection in health and social care*. Maidenhead: Open University Press.

Foucault, M. (1988). *Madness and civilization: A history of insanity in the age of reason*. London: Vintage.

Frude, N. (1998). *Understanding Abnormal Psychology: Basic Psychology*. McGraw Hill Professional.

Furminger, E., & Webber, M. (2009). The Effect of Crisis Resolution and Home Treatment on Assessments under the 1983 Mental Health Act: An Increased Workload for Approved Social Workers? *British Journal of Social Work*, 39(5), 901–917. <https://doi.org/10.1093/bjsw/bcm171>

Gilgun, J. F. (1994). A case for case studies in social work research. *Social work*, 39(4), 371-380.

Gillham, B. (2000). *Case study research methods*. Bloomsbury Publishing.

Glover-Thomas, N. (2011). The age of risk: Risk perception and determination following the Mental Health Act 2007. *Medical law review*, 19(4), 581-605. <https://doi.org/10.1093/medlaw/fwr023>

Gooding, P. (2017). *A new era for mental health law and policy: supported decision-making and the UN Convention on the Rights of Persons with Disabilities*. Cambridge University Press.

Gray, M., & Gibbons, J. (2007). There are no Answers, Only Choices: Teaching Ethical Decision Making in Social Work. *Australian Social Work*, 60(2), 222–238. <https://doi.org/10.1080/03124070701323840>

Gregor, C. (2010). Unconscious Aspects of Statutory Mental Health Social Work: Emotional Labour and the Approved Mental Health Professional. *Journal of Social Work Practice*, 24(4), 429–443. <https://doi.org/10.1080/02650531003791012>

Hall, P. (2017). Mental Health Act Assessments – Professional Narratives on Alternatives to Hospital Admission. *Journal of Social Work Practice*, 31(4), 445–459. <https://doi.org/10.1080/02650533.2017.1394825>

Hatfield, B. (2008). Powers to Detain under Mental Health Legislation in England and the Role of the Approved Social Worker: An Analysis of Patterns and Trends under the 1983 Mental Health Act in Six Local Authorities. *British Journal of Social Work*, 38(8), 1553–1571.  
<https://doi.org/10.1093/bjsw/bcm046>

Hughes, C. (1998). Learning to be intellectually insecure: the dis/empowering effects of reflexive practice. *International Journal of Social Research Methodology*, 1(4), 281–296.  
<https://doi.org/10.1080/13645579.1998.10846881>

Humphries, B. (2003). What else counts as evidence in evidence-based social work? *Social Work Education*, 22(1), 81–91.  
<https://doi.org/10.1080/02615470309130>

Humphries, B. (2008). *Social work research for social justice*. Macmillan International Higher Education.

Jenkins, N., Bloor, M., Fischer, J., Berney, L., & Neale, J. (2010). Putting it in context: the use of vignettes in qualitative interviewing. *Qualitative Research*, 10(2), 175–198.  
<https://doi.org/10.1177/1468794109356737>

Johns, R. (2004). Of Unsound Mind? Mental Health Social Work and the European Convention on Human Rights. *Practice*, 16(4), 247–259.  
<https://doi.org/10.1080/09503150500045535>

Jones, R., & Cole, M. (2014). *Mental Health Act Manual* (Seventeenth edition. ed.). London: Sweet & Maxwell.

Kemshall, H., & Pritchard, J. (1997). *Good Practice in Risk Assessment and Risk Management*. London: Jessica Kingsley.

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. Sage.

Kiteley, R., & Stogdon, C. (2014). *Literature reviews in social work*. Los Angeles: SAGE.

Kutchins, H., & Kirk, S. (1997). *Making Us Crazy, DSM- The Psychiatric Bible and the Creation of Mental Disorders*. London: Constable.

Linhorst, D. (2002). A Review of the Use and Potential of Focus Groups in Social Work Research. *Qualitative Social Work*, 1(2), 208–228.  
<https://doi.org/10.1177/1473325002001002620>

Logan, C., & Taylor, J. (2017). Working with personality disordered women in secure care: the challenge of gender-based service delivery. *The Journal of Forensic Psychiatry & Psychology*, 28(2), 242–256.  
<https://doi.org/10.1080/14789949.2017.1301531>

Lundahl, B., Yaffe, J., & Hobson, J. (2008). Today's studies, tomorrow's meta-analyses: Implications for evidence informed decision-making in Social Work. *Journal of Social Service Research*, 35(1), 1-9.

MacDonald, A. (2010). The Impact of the Mental Capacity Act on Social workers Decision Making and Approaches to the Assessment of Risk. *British Journal of Social Work* 40 1229-1246

MacIntyre, G., Lister, P., Orme, J., Crisp, B., Manthorpe, J., Hussein, S., Moriarty, J., Stevens, M., & Sharpe, E. (2011). Using vignettes to evaluate the outcomes of student learning: Data from the evaluation of the new social work degree in England. *Social Work Education: The International Journal*, 30(2), 207–222.

Maguire, N., Beyens, K., Boone, M., Laurinavicius, A., Persson, A., Robinson, G., & Svensson, K. (2015). Using vignette methodology to research the process of breach comparatively. *European Journal of Probation*, 7(3), 241–259.  
<https://doi.org/10.1177/2066220315617271>

Manthorpe, J., Rapaport, J., & Stanley, N. (2008). The Mental Capacity Act 2005 and Its Influences on Social Work Practice: Debate and Synthesis. *Practice*, 20(3), 151–162.  
<https://doi.org/10.1080/09503150802341384>

Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Forum: Qualitative Social Research*, 11(3), Bd. 11 (2010) H. 3, 19. Retrieved from  
<https://doaj.org/article/2657f6fdb8d4873b9f03b81307524ad>

McDaid, S., & Delaney, S. (2011). A social approach to decision-making capacity: exploratory research with people with experience of mental health treatment. *Disability & Society*, 26(6), 729–742.  
<https://doi.org/10.1080/09687599.2011.602864>

Menon, V. (2013). Suicide risk assessment and formulation: An update. *Asian Journal of Psychiatry*, 6(5), 430–435.  
<https://doi.org/10.1016/j.ajp.2013.07.005>

Miles, M.B., & Huberman, A.M. (1994). *A Qualitative Data Analysis: An Expanded Sourcebook*, Thousand Oakes: Sage Publications Ltd

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. Basingstoke & New York: Macmillan.

Morriss, L. (2015). Nut clusters and crisps: atrocity stories and co-narration in interviews with approved mental health professionals. *Sociology of Health & Illness*, 37(7), 1072–1085.  
<https://doi.org/10.1111/1467-9566.12285>.

Morriss, L. (2016). AMHP Work: Dirty or Prestigious? Dirty Work Designations and the Approved Mental Health Professional. *The British Journal of Social Work*, 46(3), 703–718.  
<https://doi.org/10.1093/bjsw/bcv009>

Morriss, L. (2016). Being seconded to a mental health trust: The (in) visibility of mental health social work. *British Journal of Social Work*, 47(5), 1344-1360.

Moses, J., & Knutsen, T. (2012). *Ways of knowing: Competing methodologies in social and political research*. Macmillan International Higher Education.

Newnes, C., Holmes, G., & Dunn, C. (Eds.). (1999). *This is madness: A critical look at psychiatry and the future of mental health services*. PCCS Books.

O'Dell, L., Crafter, S., de Abreu, G., & Cline, T. (2012). The problem of interpretation in vignette methodology in research with young people. *Qualitative Research*, 12(6), 702–714.  
<https://doi.org/10.1177/1468794112439003>

Osmo, R., & Landau, R. (2010). The need for explicit argumentation in ethical decision-making in social work. *Social Work Education*, 20(4), 483–492.

O'Sullivan, T. (2011). *Decision making in Social Work*. London: Palgrave Macmillan.

Patel, N., & Fatimilehin, I. A. (1999). racism and mental health. In Newnes, C., Holmes, G., & Dunn, C. (Eds.). (1999). *This is madness: A critical look at psychiatry and the future of mental health services*. P

Peterson, K. (2012). Shared Decision Making in Health Care Settings: A Role for Social Work. *Social Work in Health Care*, 51(10), 894–908.  
<https://doi.org/10.1080/00981389.2012.714448CCS> Books.

Pilgrim, D. (2014). Some implications of critical realism for mental health research. *Social Theory & Health*, 12(1), 1–21.

Pilgrim, D. (2014). *Understanding mental health: A critical realist exploration*. Routledge.

Pilgrim, D. (2017). *Key concepts in mental health*. Sage.

Porter, R. (2002). *Blood and Guts, a Short History of Medicine*. London: Penguin.

Quirk, A., Lelliot, P. Audini B. and Buston, K. (2003) Non-Clinical and extra legal decisions about compulsory admission to psychiatric hospital *Journal of Mental Health* Vol 2 pp 119-130

Sheppard, M (1990). *Mental Health: The role of the Approved Social Worker*, Sheffield: Joint Unit for Social Service Research.

Sheppard, M (1993). Theory for Approved Social Work: the use of the Compulsory Assessment Schedule, *British Journal of Social Work*, Vol 23, pp.231-237

Ramon, S. (2005). Approaches to risk in mental health: a multidisciplinary discourse. *Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress*. London: Jessica Kingsley, 184–199.

Rapaport, J., Manthorpe, J., & Stanley, N. (2009). Mental Health and Mental Capacity Law: Some Mutual Concerns for Social Work Practice. *Practice*, 21(2), 91–105.  
<https://doi.org/10.1080/09503150902807631>

Ripamonti, S., Galuppo, L., Gorli, M., Scaratti, G., & Cunliffe, A. (2016). Pushing Action Research Toward Reflexive Practice. *Journal of Management Inquiry*, 25(1), 55–68.  
<https://doi.org/10.1177/1056492615584972>

Rogers, A., & Pilgrim, D. (2014). *A sociology of mental health and illness*. McGraw-Hill Education (UK).

Russo, J., & Shoemaker, P. (1992). *Confident decision making*. London: Piatkus.

Sayce, L. (1999). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. Macmillan International Higher Education.

Schon, D. A. (1991). *The reflective practitioner: How professionals think in action*. Ashgate: Arena.

Scull, A. (2015). *Madness in civilization: A cultural history of insanity, from the Bible to Freud, from the madhouse to modern medicine*. Princeton University Press.

Sedgwick, P. (1982). *Psycho politics*. London: Pluto Press.

Sheppard, M (1990). *Mental Health: The role of the Approved Social Worker*, Sheffield: Joint Unit for Social Service Research.

Sheppard, M (1993). Theory for Approved Social Work: the use of the Compulsory Assessment Schedule, *British Journal of Social Work*, Vol 23, pp.231-237

Sowislo, J. F., Gonet-Wirz, F., Borgwardt, S., Lang, U. E., & Huber, C. G. (2017). Perceived dangerousness as related to psychiatric symptoms and psychiatric service use—a Vignette Based Representative Population Survey. *Scientific reports*, 7(1), 1-7.  
<https://doi.org/10.1038/srep45716>

Stone, K. (2018). Approved Mental Health Professionals and Detention: An Exploration of Professional Differences and Similarities. *Practice*, 1-14.

Szasz, T. (1974). *The myth of mental illness* (p. 119). New York: Harper & Row.

Szmukler, G., & Rose, N. (2013). Risk Assessment in Mental Health Care: Values and Costs. *Behavioral Sciences & the Law*, 31(1), 125–140.  
<https://doi.org/10.1002/bsl.2046>

Szmukler, G. (2018). *Men in white coats: treatment under coercion*. Oxford University Press.

Tallant, C., & Strachan, R. (1995). The Importance of Framing: A Pragmatic Approach to Risk Assessment. (1995). *Probation Journal*, 42(4), 202–207.  
<https://doi.org/10.1177/026455059504200404>

Taylor, B. (2012). Models for professional judgement in social work. *European Journal of Social Work*, 15(4), 1–17.  
<https://doi.org/10.1080/13691457.2012.702310>

Tew, J. (2005; 2004). *Social perspectives in mental health: Developing social models to understand and work with mental distress* (1st American pbk. ed.). London: Jessica Kingsley.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. *British Journal of Social Work*, 42(3), 443–460.  
<https://doi.org/10.1093/bjsw/bcr076>

Vicary, S., Young, A., & Hicks, S. (2019). "Role Over" or Roll Over? Dirty Work, Shift and Mental Health Act Assessments. *The British Journal of Social Work*.  
<https://doi.org/10.1093/bjsw/bcz014>

Warner, J. et al (2017) The historical context of the risk paradigm in mental health practice: How did we get here. In Stanford, S., Sharland, E., Heller, N. R., & Warner, J. (2017). *Beyond the risk paradigm in mental health policy and practice*. (pp 1-14) Macmillan International Higher Education.

Watson, D. (2016). Becoming an Approved Mental Health Professional: an analysis of the factors that influence individuals to become Approved Mental Health Professionals. *Journal of Mental Health*, 25(4), 310-314.

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. London: Simon and Schuster.

Watts, D., & Morgan, G. (1994). Malignant alienation: dangers for patients who are hard to like. *The British Journal of Psychiatry*, 164(1), 11-15.

Weinstein, J. (2014). *Mental Health Critical and radical debates in social work*, Bristol: Policy Press.

White, S. (1997). Beyond Retrodution? - Hermeneutics, Reflexivity and Social Work Practice. *The British Journal of Social Work*, 27(5), 739–753.  
<https://doi.org/10.1093/oxfordjournals.bjsw.a011263>

White, S., Fook, J., & Gardner, F. (2006). *Critical reflection in health and social care*. Maidenhead: Open University Press.

Whittaker, R. (2002). *Mad in America*. Cambridge, MA: Perseus.

Whittaker, R. (2010). *Anatomy of an Epidemic, Magic Bullets, Psychiatric Drugs and the Rise of Mental Illness in America*, New York: Broadway Paperbacks.

Whittle, M. (1997). Malignant alienation. *The Journal of Forensic Psychiatry*, 8(1), 5–10.  
<https://doi.org/10.1080/09585189708411990>

Yin, R.K. (1994). *Case Study Research Design and Methods*, London: Sage Publications Ltd.