How do Approved Mental Health Professionals Make Decisions During Mental Health Act Assessments? An Observational Study of Practice

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Intellectual Property and Publication Statements

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Where, after all, do universal human rights begin? In small places, close to home – so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; the neighbourhood he lives in; the school of college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerned citizen action to uphold them close to home, we shall look in vain for progress in the larger world' Eleanor Roosevelt to the United Nations in 1958

"'Cela est bien dit,' répondit Candide, 'mais il faut cultiver notre jardin', Candide, Voltaire, 1759

Abstract

This project is a qualitative research study exploring how Approved Mental Health Professionals make decisions within the framework of an assessment under the statute of the Mental Health Act (MHA 1983). AMHP's work within a clear statutory framework, with accompanying Code of Practice, and operate within both local and national policies which detail how, and in what circumstances assessments ought to be undertaken. These decisions are clearly framed within statute, and amendments in 2007 led to the implementation of a set of 'Guiding Principles' which should underpin all decision making under the Act. Alongside legislative changes to the role of the AMHP, research and reports highlight the pressures placed on these practitioners via increased workload, resource issues and a reducing workforce. The Care Quality Commission report a year on year increase in use of the MHA. This research explores how AMHPs' make decisions within this current context and if and how contextual factors effect these judgements. It is a case study design using observations of practice during 'real time' assessments of the mental health needs of individuals, combined with interviews with AMHPs and a Key Informant who was assessed under the MHA. There is a scarcity of research that explores what occurs during practice in this area and so this project contributes to furthering an understanding of this. The methods also shed light on the ethical implications of accessing a 'hard to reach' area of practice. The findings develop research knowledge around professional discretion, the impact of emotion on decision making, and values-based practice. They contribute to a conceptual understanding of the ways in which AMHPs set the scene for effective decision making, exploring virtue ethics and relationship-based practice. The contextual barriers that create challenges to AMHP practice are outlined and recommendations made to support the AMHP workforce in delivering human rights-based practice.

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Glossary/List of Abbreviations

AMHP – Approved Mental Health Professional

ASW – Approved Social Worker

COP –Code of Practice

CQC – Care Quality Commission

MHA – Mental Health Act

RC – Responsible Clinician

Chapter One: Introduction

This research was generated through an Economic and Social Research Council studentship award, aimed at increasing the investment in Social Work research within the White Rose Doctoral Training Centre. The intention, at the outset, was to explore the ways in which Approved Mental Health Professionals make decisions when carrying out Mental Health Act assessments. This topic was salient as the AMHP role had only been in operation since November 2008 further to the amendments to the Mental Health Act in 2007 which abolished the previous 'Approved Social Worker' role. Amongst a range of other changes to the statutory role one of the most significant was the opportunity for a range of practitioners other than Social Workers to take on the role. This included nurses and Occupational Therapists. During the review of the legislation that eventually amended the Mental Health Act 2007 objections had been raised that the social model approach which Social Workers were presumed to take would be diluted by professionals from a more medicalised background taking on the job (HL, HC, 2005). One of the key decisions that an AMHP is responsible for is deciding upon whether the grounds are met to apply for an individual's detention under the Mental Health Act. The act presumes that prior to making such an application all alternative 'least restrictive' options have been explored.

As my studentship included one year carrying out an MA in Social Research, I took this opportunity to explore in more depth the debates that occurred during the parliamentary review. Using a key informant interview and content analysis of a range of literature, but primarily the oral and written evidence submitted to the parliamentary review I developed a framework of understanding the debates that took place. Within the theoretical framework of an advocacy coalition approach (Sabatier & Jenkins-Smith, 1993) which seeks to provide a framework for understanding the impact of pressure groups and other stakeholders, upon development of policy, I explored the 'turf wars' that played out within the key players who contributed to the parliamentary review consultation.

This MA research highlighted that the debate around the AMHP role was focussed less on how a nurse or occupational therapist would maintain an element of independence in the Mental Health Act assessment process compared to a social worker AMHP, and more upon how any practitioner can be expected to carry out the AMHP role effectively given the changing environment within which they operated, and the myriad duties and responsibilities

inherent in the role. These are conclusions that were shared more recently in findings from Stone (2019) in a qualitative research study using vignettes to explore decision-making by nurse and social worker AMHPS. The findings suggest that whilst there were different approaches to decision making these were across the whole sample, rather than suggesting particular professional backgrounds approached MHA decision making in a particular way.

The research questions that were eventually developed for this doctoral research project were in response to the contextual challenges to AMHP decision making that became apparent through a review of available literature and within the wealth of material related to use of the MHA. The main aim of the research was to shed further light on an area of decision making about which remains a scarcity of research knowledge.

1.1 Situating the research within a longitudinal context

This research commenced in 2013 and was completed almost 9 years later in 2022. This extended timeframe was because of a variety of obstacles that arose, some within the research process and some related to life events outside the research journey. The first delay occurred due to the time it took to gain ethical approval given the observational nature of the research, in an ethically sensitive area of practice. It took a year from commencing this process to the first day of fieldwork. This part of the research journey is set out in the Methods chapter. Further delays were due to two separate periods of time on maternity leave and a suspension from studies in relation to the Coronavirus pandemic. The first pause occurred at the end of the fieldwork in 2016. Further breaks occurred from 2018-19 and again in 2020-21. The research journey was thus interrupted at the analysis stage given that the initial literature review, research design, ethics application and fieldwork all took place before the first period away from the project. The impact on the research was the passage of time when additional research and literature related to the topic was published, necessitating a strategy to ensure ongoing engagement with this literature, and also the potential impact on the relevance and saliency of the data collected. I will explicitly address the strengths and limitations of relying on research carried out within this timeframe to defend a doctoral thesis, to ensure transparency and to evidence why the design still generated findings that are highly relevant in current times.

Prior to identifying the research question, aims and objectives I carried out an in-depth literature review that I outline within the Chapter 2. This is presented as a distinct section of the chapter to ensure clarity as to the context I was working within at the time the research was designed. The research literature around AMHP decision making that became available subsequent to commencing the fieldwork for this project, a significant body of literature given the time that elapsed in the research journey, is considered in the context of the findings within the Discussion chapter, explicitly evidencing how this research is an original contribution to knowledge within the contemporary literature.

In the Discussion chapter I will also outline how developing themes around mental health law reform were considered in relation to the findings, and how the themes that came out of the analysis have clear relevance to the questions being explored more widely around AMHP practice in current times. The key issues and gaps in knowledge at the outset of the research led to the aims and objectives being developed – in light of the current context I explore if these aims and objectives enabled data to be generated that sheds light on current AMHP practice, and argue that they do.

1.2 The Role of the AMHP:

The Approved Mental Health Professional (AMHP) role is a statutory role within the scope of mental health legislation in England and Wales.

The legal duties of the AMHP are outlined in Section 13 of the Mental Health Act 2007 with its key functions being to: 'interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment which the patient stands in need' (S13 (2) and to make an application for admission if the AMHP is satisfied that it is 'necessary or proper' to do so (S12 1 (b)).

Two medical recommendations must also be in place to recommend that admission for assessment and or treatment is necessary on the grounds outlined in Section 2 and 3 of the Act: that the person is 'suffering from mental disorder of a nature and degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by

treatment) for at least a limited period; and he ought to be detained in the interests of his own health or safety or with a view to the protection of other persons'.

Local Authorities having a responsibility to put in place a 24-hour AMHP service in accordance with S13 of the MHA. Since the amendments to the MHA in 2007 the role can be undertaken by a nurse, psychologist, or occupational therapist as well as social worker (subject to carrying out additional post qualifying training), and the majority are employed by a Local Authority. Available evidence suggests that the take up of AMHP training by these other professions has been limited. For example, Parker (2010) evaluated an AMHP training course in at the University of Bournemouth and found that of 72 students only 5 were from a non-social work background. More recently, as nationwide statistics have begun to be collated to map out AMHP numbers and demographics, based on a survey of all Local Authorities it was estimated that of the 3900 AMHPS in the workforce, 95 % were from a social work background, 4 % from nursing, and less than 1 % were occupational therapists or psychologists (Skills for Care, 2021). Possible explanations for this disparity between professional groups was explored by Stevens et al (2018) and Knott & Bannigan (2013) in relation to occupational therapy. Stevens et al (2018) multi methods enquiry used surveys and interviews with 52 participants comprised of non-Social Work background AMHPs, nurses, OT's and AMHP Leads. Amongst the factors cited that deterred people from taking on the role were perceptions around working conditions, and that there were pressures around resources 'S*tress and anti-social hours; shortages of ambulances and mental health hospital beds; the impact of structural societal problems (Stevens et al, 2018, p60).*

The AMHP role first drew scrutiny during the reform of the MHA, a process that began in 1998 when the role of the applicant under the Mental Health Act was termed the Approved Social Worker. During the reform period growing evidence was provided by the British Association of Social Work (BASW), a key stakeholder in the Social Work profession, of the pressures on the role in terms of decision making (Hargreaves, 2000).

BASW called on the Mental Health Act Parliamentary Review to consider a radical reform of the ASW role, focused on what they outlined as the balancing act one individual must manage when carrying out a MHA assessment (HLHC, 2005). They argued that the decision making

role should be separated out from the 'stage management' role that was currently required of the ASW in terms of co-ordinating the assessment, negotiating practical issues such as conveyance to hospital via liaisons with police and ambulance, accommodating pets, securing property whilst also supporting the service users in the midst of the heightened emotion of an assessment. They questioned how any individual could be expected to make a balanced and informed decision within this context.

Hargreaves, (2007) representing BASW, argued that unless Health Authorities were given the statutory responsibility for managing the resource issues that accompany an assessment, the pressures on the role would increase exponentially. Whilst changes to the MHA were made and the Approved Social Worker role became the Approved Mental Health Professional, the statutory duties were relatively unchanged in terms of coordinating the assessment. Therefore, the concerns raised by BASW (2004) and Hargreaves (2007) were not addressed.

Research findings from Webber & Hudson (2012) in which a total population of AMHP's were invited to participate in a survey to elicit information primarily related to the emotional well-being of AMHP's, found that one third of AMHP's no longer wished to practice in the role and that resource pressures such as lack of access to beds and difficulties in gaining police and ambulance support during Mental Health Act assessments placed stress upon individuals tasked with being an AMHP. These findings reflected the anecdotal concerns for the role that BASW highlighted during the 2007 Mental Health Act reform processes - that unless significant changes were made to the job there would be a crisis within the workforce due to issues such as an ageing workforce with a lack of new recruits due to the undesirability of the role and its accompanying pressures.

1.3 Key Literature: Setting the context of the Research Topic

Alongside pressures that were evidenced in relation to the AMHP role (e.g. Furminger & Webber, 2009), wider concerns were being raised in terms of trends in use of the Mental Health Act. The context of these concerns at the time this research was designed is summarised in key findings from the Care Quality Commission's Report on the Use of the Mental Health Act 2011/12 (2013). This outlined anecdotal evidence from a range of

stakeholders involved in the workings of the Mental Health Act. For the purposes of this research the following points are salient:

- '*Pressures on beds continued to put services and patients under stress, making it harder to provide appropriate care for people in times of crisis. In 2011/12 93 wards (6% of all wards) visited had more patients than beds, a further 10% were at full capacity' (CQC, 2013, p52)*

- *'In one authority, AMHP's felt that Crisis and Home Treatment Teams were underperforming in their role to provide practical support as alternatives to hospital admission' (CQC, 2013, p54)*

- *'AMHP's in another authority said that their hospitals seemed to have an 'aversion' to voluntary patients, and that there were significant difficulties in finding a bed for voluntary patients which they felt as a pressure to use the Act. In other authorities AMHP's also told the CQC that they feel pressure to use detention under the Act as a means of ensuring access to a bed' (CQC, 2013, p54).*

Other issues identified in this report included a lack of alternatives to admission in rural areas and long waits for transport to take someone to hospital once a decision has been made to detain them to a psychiatric hospital (CQC, 2013). The overarching concern was the impact these resource-based issues were having on the quality of care of patients/service users and understanding why detention rates were increasing.

Explanations for the trend in year on year increases in use of the Mental Health Act included:

- *Admissions being delayed due to shortages of in-patient beds and patients being discharged at an earlier stage of their recovery due to this resource pressure (Keown et al, 2011). The Mental health crisis care concordat recognised that outcomes are*

improved for individuals when access to services occurs speedily during a crisis (HM Government 2014).

- *A developing culture of risk aversion within practitioners (The Schizophrenia Commission, 2012, Glover-Thomas, 2011).*
- *Conditions on inpatient wards deteriorating with overcrowding, staff shortages, and patients less likely to agree to informal admission (Jones et al, 2010)*
- *Socio-economic factors impacting on mental wellbeing with increases in social isolation, exclusion, and substance misuse (Tew, 2011).*
- *Service users less inclined to defer to professional judgement about the best way to meet their needs (Brown et al, 2009)*

A statistical analysis study carried out by Keown et al (2011) examining data collected by the Hospital Admission Statistics and Involuntary admissions rates, for the period from 1988-2008, evidenced a relationship between a reduction in inpatient beds and an increase in admission under a section of the Mental Health Act. Whilst the authors do not offer qualitative commentaries on this trend the study does provide a reliable statistical analysis of a total population over a twenty-year span. This trend was formally acknowledged by the Government in their response to a Parliamentary Scrutiny into the Implementation of the Mental Health Act 2007 (DofH, 2013). Of the 12 recommendations made the top priority was an urgent investigation into whether 'patients are being detained to access psychiatric unit (DofH, 2013, p3). A statement was issued by Louis Appleby, CQC Board member on this matter:

'*We have heard anecdotal evidence that patients may be detained under the 1983 Act simply to obtain access to an inpatient bed. Our view is clear: the principle of least restriction is a fundamental consideration for professionals making decisions about a course of action under the Mental Health Act. Detention solely as a mechanism to secure access to hospital treatment would not be lawful and if the hospital or local authority staff think it is happening, or feel pressured to admit people in this way, they should report it to their trust – and if necessary the CQC' (DofH, 2013, p3).*

This was a key concern at the time this research was developed and at this time the discourse was around unlawful use of the Mental Health Act. This was of relevance to policy makers as if unlawful practice occurs because of cuts to services, legal cases can be brought against Local and Health Authorities in relation to breaches of Human Rights legislation (for example the case of DD vs Durham. (DD v Durham County Council [2013] EWCA Civ 96, [2013] MHLO 31) DD argued that an inpatient admission breached his rights under Articles 3 and 8 of the European Convention of Human Rights. The issue was of relevance to practitioners who may feel forced into acting unlawfully as the only way to secure a bed for a service user that requires admission. It had relevance to managers who may make budget decisions and inpatient bed cuts based on guidance from central government. However, arguably it was of most relevance to the individuals who may be detained unnecessarily due to there being a failure by statutory services to meet their needs either to prevent admission via better provision of services within the community, or by barriers to admission unless a person is on a 'section' of the MHA.

Oral evidence given to the Post-Legislative Scrutiny of the Mental Health Act 2007 (DofH, 2013) provided a service user perspective of their experiences of being made subject to the Act. For example:

> *'We have cases where someone has reached an absolute crisis, through lack of services in their own area, has had no access to support and has ended up in Bethlem hospital for five weeks before a care plan was even gone through'* (HCHL, 2013, Ev21).

This anecdote suggests a breakdown of support from services both pre and post admission and further evidence suggests that due to poor regard for the care and treatment available as an inpatient, less individuals are minded to agree to informal admission (that is, not on a 'section of the MHA). For example, '*People have a bad experience of care before they go into hospital, so that they are already frightened and scared on the hospital ward'* (HCHL, Ev 22).

A media campaign led by the College of Social Work put forward a list of possible reasons for the trend towards increasing use of the MHA based on anecdotal evidence from practitioners and service users, and pressures on services. These included:

- *People not knowing where to go to access urgent help.*

- *Difficulties in accessing an urgent psychiatric bed.*
- *Social and Financial pressures placed upon people because of the current economic climate and stressors of welfare reforms.*
- *Fewer people receiving preventative social care due to changes and reduction in health and social services.*
- *The AMHP role is unrecognised and under resourced (*Guardian Social Care Network, 2013).

1.4 Contemporary Issues

Over the subsequent decade these key issues have remained pertinent and have led to further work to reform the Mental Health Act (DHSC, 2022a). This was led by a Conservative Party agenda '*to stop the year on year increase in the use of compulsory powers and to address the stark race inequalities in its use*' (Centre for Mental Health 2019, p1). A key report, providing an Independent Review into MHA reform from Wessely et al (DHSC, 2018) made a series of recommendations which marked a shift towards rights-based practice underpinning any proposed reform.

> *'I continue to believe that it is at times reasonable to make a temporary infringement of liberty and autonomy, and even impose treatment on people who do not want it. But we have to do better in ensuring that no one is made worse than they would have been without this imposition, more are made better, and all have their dignity respected. Likewise, as far as possible they should still be able to make choices as to how they are treated'– Simon Wessely, Modernising the Mental Health Act,2018, p6'*

A policy position statement from the Centre for Mental Health (2019) sets out the findings from nine key pieces of research conducted into a range of topics including trends in use of the Act, alternatives to admission such as the use of crisis intervention, and the experiences of individuals subject to MHA assessment and their family members/carers. This research was collated and summarised to highlight the key issues where empirical research evidence indicated factors that were impacting on use of the MHA to inform the Independent Review of the MHA. These were summarised as:

1. *The impact of the implementation of the Mental Capacity Act in 2005 on decision making – where a person was assessed as lacking capacity to consent to admission detention under the MHA is more likely.*
2. *An observed steady increase in the prevalence of mental health problems in the population as a whole (p3)*
3. *Despite an increased number of people accessing mental health services, community resources had not increased correspondingly, making it harder for people to access support to prevent or manage crisis and relapse of mental ill health* (DHSC, 2019, p3).

The Policy paper highlights that the research findings did not provide empirical evidence that austerity and a reduction in inpatient beds had impacted on use of the MHA.

Key debates have now shifted from discussion around unlawful use of the MHA to wider concerns about the availability of beds and community resources as alternatives to admission. Significantly the Coronavirus pandemic has had an impact on mental wellbeing and has correlated with increasing numbers accessing mental health services and increasing concerns being raised about the availability of community resources to prevent admission (CQC, 2022).

Of note is the raised profile of the AMHP role, in part due to the Social Work profession having a new regulatory body, Social Work England. They are tasked with approving and monitoring AMHP training courses.

This is in marked contrast to when I trained as an Approved Social Worker via a local training provider. The course is now led by Higher Education Institutes and is a post graduate level course. Social Work England have established a set of criteria, based upon regulations set out in Schedule 2 to the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 that trainees AMHPs must evidence to become an AMHP. These include meeting criteria around informed decision making:

- *Be able to evaluate critically local and national policy to inform AMHP practice.*
- *Be able to draw on, and evaluate critically, a range of research relevant to evidence based AMHP practice.*
- *Be able to gather, analyse and share information appropriately* (SWE, 2020).

Alongside the new regulatory body (established in 2020) the Department of Health and Social Care have appointed a Chief Social Worker and a Mental Health Social Work Lead with responsibilities including involvement in Mental Health Act reform, '*strengthen AMHP workforce arrangements*' and develop monitoring tools of AMHP activity (DHSC, 2022b). The DHSC have also developed an AMHP workforce development plan alongside key partners including Skills for Care and Social Work England (Skills for Care, 2019). This document collates research around the AMHP role and reporting around contextual pressures to set priorities to address the identified issues. This can be considered a hugely increased focus on the role, with plans for clear monitoring frameworks to report on the AMHP role.

A view from Ruth Allen, Chief Executive of the British Association of Social Worker, reported by Carson (2018) is that:

> *"Data is power. If we really start to look at the level of need, how many staff have you got, it then starts to expose the pressures on referrals."*
> *Allen says the lack of national data about AMHP activity, with statistics instead focused on local services, means "everything is all about how this or that council provides a service". "The upshot is that this quite risky and very pressurised work has stayed a bit off the radar," she adds. "It has been quite convenient at national level to not know what's happening' (Carson, 2018).*

This suggests that there has been a political agenda in terms of lack of attention to the AMHP role, with suggestions that empirical data to shed light on the pressures that have been reported anecdotally may lead to more accountability from Central Government.
Issues that are reported as requiring closer scrutiny include the demographics of the workforce as AMHPs tend to be an older workforce, with an impact on retention and recruitment to ensure enough AMHPs are in role.

The AMHP workforce development plan (Skills for Care, 2019) explores a range of challenges for AMHP practice including increasing the numbers of non-Social Worker background AMHPs to increase numbers, implement clearer pathways for training and continuing professional development. Locally it is recommended that:

> '*Local authorities, MH Trusts and STPs should monitor the morale, pressures and workload of their AMHP services and the professionals who work with and support AMHPs. There should be regular audits of these issues and plans to resolve problems through a 'whole-system' regional approach' (Skills for Care, 2019).*

The AMHP workforce development plan also has a recommendation that the AMHP practice should be subject to regulation and inspection via the Care Quality Commission, who regulate all other activity carried to within the jurisdiction of the Mental Health Act. Many of the plans link to recommendations made by Campbell & Davidson (2010) almost ten years prior, in response to an audit of ASW practice in Northern Ireland.

In summary, concerns around use of the MHA, the role of the AMHP and how decisions are made within the scope of the Act remain pertinent and evolving. Indeed, MHA reform is a 'live' topic with the White Paper being published in the same month as this thesis was submitted (DHSC, 2022a).

The research remains original in its aims and objectives as a qualitive enquiry using observational methods to explore decision making of use of the Mental Health Act. It seeks to contribute to a clearer understanding of what drives decision making, the motivators and factors that come into play and the views of those operating within modern mental health services and statute. I am interested in exploring what impact these 'pressures', as identified by the CQC may be having on practitioners and from what source they originate. The research is also concerned with gathering a service user perspective on the lived experience of being at the sharp end of these 'pressures' and the way in which these are conceptualised by these individuals.

1.5 Researcher Standpoint

As a Social Work practitioner the research topic is of particular interest to me as I have worked as an Approved Mental Health Professional and Social Worker within a Community Mental Health Team, and as such have been responsible for making decisions under the Mental Health Act, primarily deciding whether or not the grounds were met to apply for detention for assessment or treatment as per Section 2 and 3 of the MHA. Working within this field I was aware of the pressures I encountered as an individual and the anecdotal experiences of colleagues. For example, delays in identifying inpatient beds, an increase in service users

being placed in so called 'out of area beds' with the accompanying impact on access to family, local community and other factors which arguably are factored into an individual's 'recovery'. As a practitioner researcher I inevitably bring along an inherent bias to the research but threaded throughout the thesis I reflect on this and defend and critique my position as appropriate. Maintaining a reflective diary during the research process, as advocated by Fook (2002) ensured greater transparency in accounting for the direction that the project took and ways in which the analysis was undertaken.

Alongside the changing context of mental health practice that occurred alongside this research- most significantly the move to further Mental Health law reform - inevitably I have also developed personally and professionally as time has passed. Notably in the early days of the research I identified very strongly as an AMHP as I continued to practice in an Emergency Duty out of hours team, carrying out Mental Health Act assessments. During the fieldwork I was still practicing as an AMHP. Due to a change in personal circumstances – becoming a parent – I decided to stop working as an AMHP in 2015 and moved away from mental health practice more generally. In recent years I have been employed in managerial roles within social care, involved in policy development, writing local practice guidance based on Policy and statute, and have been involved in research collaborations. Whereas my standpoint at the outset of the research was clearly 'practitioner-researcher' I identify more closely now as a 'research- practitioner'. I have some 'distance' from the research project as I am not immersed in the world of AMHP practice as I had been for 10 years prior to stepping back from the role. I will reflect on this shifting standpoint during the discussion chapter as the lens through which I analysed the data had changed since the fieldwork days. For example, when the reflective memos were written I felt much more emotionally involved in AMHP practice and shared a sense of collective identity with the AMHP practitioners who participated in the observations and interviews. Arguably this subsequent distance enabled me to put different questions to the data generated by the research methods – I will explore this during the discussion.

1.6 Summary

This Introductory chapter has set the scene for the research, outlining the context of the AMHP role at the outset of the project, considering developments in terms of use of the MHA and Mental Health legislative reform. I have outlined the research problem, presented key

literature that highlights gaps in knowledge around AMHP decision making, and discussed my standpoint as an AMHP and Social Worker.

Chapter 2 explores a wide range of literature of selected as being of relevance to the research 'problem'. I set the scene within which the research is situated, that is, a potted history of the historical development of mental health services within the UK (e.g. Porter, 2002, Bentall, 2004, Miller & Rose, 1986). Alongside this, I consider the wider theoretical questions around mental health discourse and models of understanding mental disorder, how this is defined and understood within western culture. The literature review then moves on to explore empirical research around AMHP decision making, models of decision making, professional identity, discretion, professional ethics, and the role of professionals when implementing policy into practice, exploring in particular the concept of 'street level bureaucracy' (Lipsky, 1980). Consideration is also given to the power dynamics operating during a Mental Health Act assessment, identifying the 'key players' and exploring research and theoretical frameworks that shed further light on decision making in the context of risk and organisational pressures. This sets the scene to outline the research questions, aims and objectives.

Chapter 3 explores research theory, methodology, design, the process of gaining ethical approval, and discussion around how the fieldwork required a reflexive, ongoing consideration of what it is to be an ethically engaged researcher. This chapter includes reflection on the nature of the data that was collected as access to observations was limited due to issues around eligibility criteria and consent to use of data. This is outlined and explored, setting out the ways in which it was necessary to reflect and adapt the research process to answer the research questions.

An account of the analysis is provided and a rationale for the choice of approach to analysing the data.

Chapter's 4 and 5 outline the research findings, drawing upon an analysis of field notes and reflective memos to tell the story of a Mental Health Act assessment from the point of referral to the face to face assessment of an individual, and the decisions an AMHP is required to make at all points of this assessment journey, 'How AMHPs do what they do'. These themes

are then considered alongside the interview data from reflective conversations with the AMHP participants, 'how AMHPs talk about what they do'.

Chapter 6 provides a discussion of the findings and demonstrates how the research sheds further light on the gaps in knowledge around AMHP decision making. It evidences how the research provides an original contribution to knowledge that contribute to a conceptual understanding of AMHP decision making, professional identity. This chapter also considers the recent development in AMHP research and sets out the ways in which the findings are contemporary and relevant when considered in this context. A consideration of the impact of the Coronavirus pandemic and Mental Health Act reform are also explored in the context of the findings.

Chapter 7 provides a conclusion to the study with the limitations of the study explored, ideas for future research and the relevance and implications of the study for research, policy, and practice. The impact of the research will also be made explicit in this discussion, and suggestions for future research and current practice guidance.

A note on language: As will be explored in the literature review, the use of language within the mental health field is contested and has the potential to empower or disempower individuals experiencing mental health issues. In brief, my position allies itself with the Social Model of Disability (Beresford et al, 2010) and I take the view that historically society tends to discriminate against and socially exclude those individuals who are diagnosed with mental illness (see Sayce, 2000) These debates are extended in the following chapters. As arguably language is used as a means of reducing this discrimination and restoring some of the power imbalance that has historically rested disproportionately with the decision makers – I therefore use the title 'people with lived experience' interchangeably with 'service user' noting that service user can have some negative connotations. This is reflective of the shifting times since the research was designed. Whilst I would not choose to use this term now at the time of writing the ethics application, I adopted this term in preference to the term 'client'.

Chapter 2: Literature Review

2.1 Introducing the Chapter

This chapter is structured into the following parts:

- A summary of the Literature review technique,
- A critical analysis of the theoretical, empirical, policy, and practice literature related to AMHP decision making
- An outline of the research questions, aims, objectives

To set the scene in terms of the area of practice within which the AMHP role is situated, a brief overview of mental health policy and law will be provided. Next the empirical research related to the AMHP role is critically evaluated, delineating between the research that was available at the outset of the research and research design, design and research that became available later.

I then outline and critically evaluate the theory around professional decision making and explore concepts such as Professional Discretion and Virtue Ethics in relation to decision making.

Finally, the research questions, aims and objectives are set out, defending the ways in which they sought to develop research knowledge to address the gaps as identified in this appraisal of the literature.

2.2 Search Strategy and rationale

Key search terms: Approved Social Worker, Approved Mental Health Professional, professional decision making, professional discretion, Mental Health Act, Risk AND Mental Health Act, Experience of being assessed under the Mental Health Act

Databases used: PsychINFO, Social Care Online, Google Scholar.

I took a narrative approach to the literature review to elicit a wide range of material in relation to the research question. Whilst systematic reviews can be considered the 'gold standard' in terms of an approach to critically appraising literature in relation to a research question

(Pawson et al, 2003, Smith & Noble, 2016), due to my familiarity with the research topic I was aware that at the onset of the research there was little empirical research exploring the topic of AMHP decision making. To set the scene for AMHP decision making I took a conscious decision to appraise a wide range of literature to examine the wider context of AMHP practice in terms of the discourse around mental health policy. In addition to the knowledge generated by existing research in the field, consideration of policy, parliamentary review papers, key informant commentaries and case law proved invaluable in generating a framework for understanding the context within which the research problem is situated. Literature that portrayed the experiences of individuals who have been made subject to the Mental Health Act was also sought. This approach is advocated by Pawson (2006) and thus I borrowed from a realist synthesis approach to literature review.

As referred to in the Introduction, one impact of the longitudinal nature of the research (given the delays and interruptions in the research journey), was the need to ensure an ongoing engagement with contemporary literature related to the research topic. The substantive literature review was carried out in the early stages of the research journey to inform the development of the research question and design. This part of the research journey took place without interruption. However, given that a year elapsed from the commencement of the ethics application, to gaining approval and commencing the fieldwork, I remained engaged with the literature via regular searches via the databases identified earlier in this chapter. I consider that the most significant event in the research journey that impacted on the development of this Literature Review, was the year pause at the end of the fieldwork. This and the subsequent pauses in the research necessitated that whilst the research question and design were informed by contemporaneous literature, the analysis was carried out in the context of a growing body of AMHP related literature given the policy and research focus the role has been given in recent years.

I began this research programme by conducting a literature search using key health and social care academic databases but the challenge to remain abreast of the literature throughout the nine year research journey was managed by carrying out regular searches of relevant health and social care databases and also checking resources via the Department of Health and Social Care, British Association of Social Work, Community Care Inform, Social Care Institute of

Excellence (SCIE), Skills for Care, The College of Social Work (until its demise), Social Work England, The Care Quality Commission and Research in Practice.

The AMHP research community is also a generous space in terms of nurturing ideas and sharing resources and I became aware of research papers via these research networks. Of note was the impact of online 'communities of practice' which developed through online networks such as twitter. These online forums also alerted me to new publications and hand searches led to further insights. This also served as a source of motivation as a reminder of the saliency of the research questions I was exploring.

Given the prominence of debates within the media in relation to Mental Health Act reform this also served as a source of knowledge in terms of policy developments and to gain insight into the dominant discourse around mental health policy, which shifted over time.

Whilst Feltham (2005) in Pease (2012) warns of the risk of research being devalued if it relies upon so called 'grey literature' they also argue that in relation to evaluation of practice issues, this type of knowledge is essential to include (albeit it with a critical eye).

2.3 Mental Health Policy and Practice: The Historical context:

In England and Wales health and social care is delivered via health and Community Care policy and legislation, notably the Mental Health Act 1983.

A Joint Parliamentary Committee Briefing (HoL, 2005), in the context of reforming the MHA 1983, summarises the history of mental health legislation within England and Wales. The report highlights the competing priorities of the allocation of resources, public safety and individual patient care that underpinned the development of legislation:

> *'Mental health legislation has at least three centuries of history behind it. Many of the issues which the current Government and this Joint Committee have had to address would be familiar to our predecessors since at least the beginning of the 19th century…..it is an issue which raises fundamental questions about the personal autonomy and liberty, the role of the state and the extent of its powers and responsibilities, public attitudes towards people who are mentally-ill, developments in medical and behavioural sciences, the clinical judgement of medical practitioners and*

other professionals and complex questions of medical science, ethics and belief' (HL Paper 79-1, HC, 95-1, 2005, p8).

To provide an example of the intersection of the state and mental health, Porter (2002) considers the role of politics and social control in the development of an approach to 'madness' as far back as the 17th Century. After the English civil war religio-political extremism was discouraged and thus viewing madness as spiritual/mystical in origin (as had been the causal explanation) was '*deemed ruinous to public order and public safety alike'* (p28)

It is beyond the scope of this literature review to explore this history in great depth, but some understanding is necessary to situate the AMHP role within this socio-medical-political context.

Lester & Glasby (2006) outline the timeline that seeks to set out the origins of state interventions in mental health and the formation of institutionalised care within hospital settings, exploring the relation of statute to modern Mental Health Statute:

- 1377 – Bethlem Hospital opens and admits 'distracted' patients.
- The Madhouses Act 1774 – enables a form of regulation to oversee privately run 'madhouses' that had increased in number over the previous century.
- The Lunatics Act 1845 - led to the establishment of publicly owned asylums.
- The Lunacy Act 1890 – the emergence of legislation concerned with protecting civil rights for people living outside institutions
- The 1930 Mental Treatment Act -placed duties upon Local Authorities to provide mental health services
- The 1959 Mental Health Act – led to the implementation of The Mental Welfare Officer (the predecessor of the ASW) and the foundations of the Mental Health Act 1983.

The reform of the Mental Health Act in 2007 was heavily influenced by calls from a range of pressure groups and interested parties, to consider the rights of the individual being assessed (Mental Health Alliance, 2004). According to the Department of Health (2013) debate ensued as to whether these underlying principles should be integrated into the primary legislation.

They were eventually written into the Code of Practice with Section 118 of the MHA ensuring that the principles must be taken into account by listing the key areas that decision makers must consider. The 'Guiding Principles' should be 'considered' when making decision under the Act MHA Code of Practice, Para 1.1, reinforcing the focus on the individual being assessed). According to the Department of Health (2013) they are intended to 'inform every decision made under the Mental Health Act 1983 and improve the quality of services for people who come under the provisions of that Act' (p7)

The Guiding Principles:

- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness
- Efficiency and equity (DH, 2015)

Due to the lack of regulation from the CQC into AMHP practice there is no clear monitoring framework to understand how these Principles are embedded in practice.

2.4 Setting the Scene: A Critical Perspective

Mental Health legislation is based on an a priori assumption that Mental Illness is a fact or a truth. Critics such as Pilgrim (2015) challenge this assumption on the basis that an understanding of 'otherness' or 'madness' as defined and diagnosed as mental disorder, is a contested phenomenon. This approach to understanding madness as a social construct has been written about extensively (e.g. Pilgrim & Rogers, 2010, Horwitz, 2012, Laing, 1960, Beresford, 2013) with some critics proposing the abolition of compulsory mental health care (Sayce, 2000). Eisenberg (1988) bases an understanding of the social construction of mental illness on four premises, which problematises the basic assumptions held about mental illness:

> '*First, that all scientific concepts are inventions of the imagination. Second, that the human sciences are beset by a paradox: what is believed to be true about behaviour*

> *affects the very behaviour which it purports to explain. Third, that the trajectory of illness is influenced by the beliefs patients and doctors hold about course and prognosis. Finally, that physicians, no less than their patients, are constrained by socially constructed roles' (p1).*

In the context of a MHA assessment, Kinney (2009) suggests that the criteria for use of the MHA is based upon a 'false premise' given that dispute remains as to the nature of 'madness' and the medical model that underpins the Act. He outlines the context within which MHA assessments take place and argues that they are 'like experiencing first hand a labelling theory experiment' (Kinney, 2009) based on a psychiatrist spending twenty minutes interviewing an individual to ascertain if they are experiencing a mental disorder.

Pilgrim and Rogers (2011) take the approach of considering modern day mental health practices through the lens of comparing acts carried out under the MHA with other areas of a person's life:

> *'Certainly in any other circumstances, may of the actions associated with the enforced detention and treatment of some mentally disordered people would leave perpetrators open to charges of abduction, false imprisonment and assault. The existence of 'mental health law' protects agents of the state from these charges' (p263)*

They suggest that as a defence practitioner's 'close ranks' and develop a narrative that justifies their actions regarding use of the MHA. This could be considered the dominant discourse that threads throughout all elements of statutory mental health practice.

Pilgrim (2015) encourages a questioning approach to mental health policy and to consider where assumptions about the nature of mental health problems arise, to critically reflect upon how this impacts upon practice.

2.5 Paradigms of Understanding Mental Illness: The Individual/Medical Model, The Social and Human Rights Models of Disability and the Survivor movement

Whilst the libertarian stance of Sayce (2000) can be considered an ontological positioning in relation to the concept of mental illness (the 'myth of mental illness', Szasz, 1974) other

models can be regarded as epistemological positionings around situating concept of mental health.

For example, driven by the disability rights movement, the Social Model of Disability is underpinned by values round social justice and anti-discrimination, with the standpoint that people are disabled as a consequence of the barriers and attitudes imposed by society, rather than as a consequence of the impairment that they have (Barnes, 2019). Beresford et al (2010) carried out research exploring the views of people with lived experience of mental health issues, towards the Social Model of Disability as a model for promoting a rights-based approach to conceptualising mental health issues. These findings summarise key concerns that whilst dispute remains over the cause of mental distress, this model has limits in addressing these conflicting assumptions.

The polar opposite of this concept is the Individual, medical model of understanding mental illness, where behaviours are attributed to physiological, genetic, or functional causes, that can thus be treated with medication (Huda, 2019). Miller and Rose critique (1986) what they consider a simplistic view of the power Psychiatry and Psychiatrists have within the field of mental health. They challenge ideas around Psychiatrists being agents of social control and there is one over-arching 'power' that they adhere to. This, they argue is too simplistic and they offer a model to understand the nuances of the psychiatric profession and the development of mental health services placing the discussion within a historical examination of the subject area. They counter to what Rose argues are the dominant sociological and political discourses of recent decades i.e. the medicalization of madness. Rose identifies how mental health has diversified into a range of professions and services and to offer psychiatry as a 'straw man' is to disregard the growth of these allied professions and also the shift within psychiatry to acknowledge the impact of social stressors and 'psychological' explanations for madness.

Parallel to the Social Model of Disability is a movement within mental health termed the 'Survivor' movement (Barnes & Bowl, 2001). A co-produced definition of the movement is offered by Wallcroft et al (2003)

> '*The 'service user/survivor movement' is a term used to describe the existence of numerous individuals who speak out for their own rights and those of others, and local*

> *groups and national organisations set up to provide mutual support or to promote the rights of current and former mental health service users to have a voice. Group members and individuals may call themselves 'survivors', 'service users', 'clients', 'ex-patients' or other similar terms. The term 'movement' implies that these individuals, groups and organisations share some common goals and are moving in a similar direction (p3)'.*

These goals were described as:

- Wanting to change mental health services
- Seeking alternatives
- Mutual support about shared issues

One of the primary concerns raised by the Survivor movement is the focus on risk and perceptions around dangerousness. This was evident in the discourse around the amendments to the MHA in 2007 which were made within in the context of high-profile murders and accompanying media reporting that around mental health and dangerousness. This extract from the Mental Health Act White Paper in 2000 illustrates this:

> '*The Act has failed to protect the public or patients as the tragic toll of homicides and suicides by mentally ill people shows. That failure has undermined public confidence in mental health services' (DofH, 2000, p 15).*

In recent years this polarisation of understanding mental health has, arguably developed to a more nuanced position. The MHA continues to be underpinned by definitions of mental disorder as diagnosed via the Diagnostic and Statistical Manual, as criteria for compulsory assessment and treatment, as diagnosed by a medical doctor (a psychiatrist). However, psychological, and sociological understandings of mental health are also considered mainstream with the development of a range of psychological therapies developed to manage the experiences of people diagnosed with various conditions. For example, so called psychosocial approaches to understanding mental distress Morrison et al (2008), Greenberger and Padesky (1995) which are embedded in NICE treatment guidelines (NICE, 2015), and the increasing use of Cognitive Behavioural Therapy on a wider scale via

programmes such as Increasing Access to Psychological Therapy (IAPT) Clark (2018). There has also been growing discourse around alternative ways of understanding the experience of voice hearing and unusual beliefs (e.g. Romme & Escher, 1993). The NHS Long Term Plan (2019) includes commitments around improved access to psychological therapies and has implications for wider services such as 24-hour mental health crisis care.

Evidence suggests that the language and focus on current Mental Health Act reform takes a rights-based approach with a shift in the discourse around understandings of mental health issues. Human Rights Based practice has developed as distinct from the Social Model of Disability, and perhaps resolves some of the tensions in applying the Social Model of Disability to mental health as it allows space for ongoing debate about the nature of experience that is defined as mental illness. Lawson & Beckett (2021) propose that the two models can align rather 'improve' upon the Social Model of Disability. Ideas around coproduction and the Recovery Model have also developed. The introduction by Simon Wessely to the Independent Review of the Mental Health Act (2018) summarises this shift:

> *'The rhetoric surrounding the genesis of this Review could hardly have been more different from that of 20 years ago. The Terms of Reference of this Review speak about the problems of the rising rate of coercion, seen as something undesirable, as opposed to the aim of public policy. Discrimination and stigma, especially towards ethnic minorities, is specifically included. Likewise, I was tasked to see If the Act is up to date in how it deals with human rights (it isn't). During the time of this Review, neither myself nor my three Vice Chairs have experienced any political pressure to shape our decisions in a particular direction'* (DHSC, 2018, p9)

Considering these underlying models of understanding mental illness is of relevance to the research topic as it sets the scene in terms of the shift in the dominant paradigm around how society perceive mental illness and how mental health law reflects this – or not. Whilst the AMHP is required to consider the social circumstances of the person who is being assessed, they are situated within a wider socio-political with differing views on the nature of mental health.

Socio-political Theory and the relevance to Mental Health decision making

Writing in the Independent Review of the Mental Health Act report Wessely raises concern about the shift towards increasing focus on risk within mental health services, and cites this as a potential driver for increasing rates of admission under the MHA:

> '*The importance of risk management and safety has steadily risen across society – as reflected in some key sociological texts. It is seen by many as a principal driver in modern society, so it is not surprising that it has become very influential in medicine as a whole, partly driven by scandal and perceived failings. But there are few places where it has achieved the prominence or dominance that it has in mental health, and this happened over a relatively short period of time. When I started my first post in psychiatry in 1984 risk assessment was taught to everyone in the context of deliberate self-harm, but in general it was forensic psychiatry that was most concerned with it, and where most of the relevant research originated. But within a few short years this had changed*' (DHSC, 2018, p9).

Rose (1999) also explores the shift in focus (within psychiatry) from clinical diagnosis to assessment of risk, often utilising the technological advances that he suggests underpin our society – a sense of feeling protected and secure as information can be coded, quantified and risk assessed. *'Confinement becomes little more than a way of securing the most risky until their riskiness can be fully assessed and controlled' (*Rose, 1999 p261).

Goffman (1961) explores the impact of living within an institution based on research carried out in the USA during the 1960's. He considers the ways in which people behave are influenced by the social conditioning they are subjected to, for example the routines of the individual institution. Goffman explores the concept of 'The moral career of the Mental Patient'. This suggests that people begin their career as 'patients' due to factors in addition to their mental state. He argues that individuals are subject to 'contingencies' that is, the influence of others on their situation. For example, the perceptions or behaviours of others leading to a behaviour being perceived as requiring intervention from mental health services. This might be a partner who grows tired of an individual due to other factors as a consequence of their own issues (problems at work etc) or a new neighbour moves in who is not agreeable to being waken in the middle of the night by loud music and calls the police out. Goffman (1961) also explores what is termed an 'alternative coalition' – if a third person (e.g. a mental

health professional) witnesses the events pre admission it becomes a 'public social fact' and the sense of betrayal and abandonment is increased for the patient.

This has relevance to decision making within the scope of the MHA as this considers the wider societal impact of detention under the Act. For example, the journey of an individual from being a non-patient to a patient – considering the impact on role and identity of being admitted informally or against a person's will. It also sheds light on the ways in which perceptions of risk can shift dependent upon the wider social factors that are present.

Glover-Thomas (2011) carried out research exploring the ways in which those involved in MHA assessments define risk – both within and between professional groups. The research used semi structured interviews with 19 participants from a range of professional backgrounds. She explores what she describes as a shifting focus to risk but lack of clarity within and between professional groups in terms of how they understood it:

> *'Risk terminology now has a common usage within the clinical setting yet defining this notion or giving it some clearer definition remains elusive. Participants of the research recognised that despite reference to and use of 'risk' within their daily activities, they did not have a working definition upon which they relied. Indeed, participants offered circular definitions or restated or paraphrased the statutory criteria for compulsory admission—what has been called in this paper, the 'risk is risk' paradox: decision-makers cannot define risk in the abstract, but they know it when they see it' (Glover-Thomas, 2011, p23)*

Commenting on rising detention rates Webber (2012) argued that there is a role for Mental Health Social Workers as they 'can help to challenge the prevalent discourse of risk in mental health services. (Webber, 2012).

Foucault (1973) outlines the case of Pierre Riviere–an account of a murder viewed through the lens of a variety of professions, all of whom can be considered to be vying for their position to be privileged. The 'moral' of the tale is to shed light on how standpoint and value base can lead to a different interpretation of the same narrative, and the shifting nature of this in relation to concepts of power.

Considering this tale alongside Goffman's (1961) ideas around contingencies suggests that narrative always changes and is socially constructed to support an individual's view at a given point in time. In relation to AMHP practice this has relevance in terms of how they gather information to make a decision and then synthesis this based on an interpretation of a storyline. For example, how do they consider other narratives and is it difficult to change the course of this dominant narrative based on the referral that they receive and the 'headline' news regarding risk. A consideration of risk in this context suggests that it is necessary to understand the social norms, culture, and dynamics of relevance to the individual that is being assessed.

Ridley et al (2009) carried out participatory research with people who had been detained under Scottish Mental Health law. They explored the events leading up to compulsory admission with 49 'service user' participants were recruited to take part in interviews and focus groups around their experiences. The findings suggest that the journey from 'non compulsion' to compulsion is not linear:

> *'In summary, individuals' accounts of the state of 'non compulsion' and the 'episode' leading to compulsion, suggested that in reality so called 'stability' was for many a fraught and uncertain time, ad that the pre-compulsion 'episode' may better be represented in terms of the interplay of personal or health crises with carers' and professionals responses, rather than as a specific event'* (Ridley, 2014, p138).

Arguably this account has resonance with the ideas of Foucault and Goffman in terms of perception and the impact of factors beyond the manifestation of mental distress.

Spandler (2014) writes that:

> *'Good decisions about compulsory mental health care should be based on an understanding of the prevailing context, a person's needs and the relationship the professional has with the person concerned. This is often difficult for approved mental health practitioners who usually have insufficient time to develop relationships with people being assessed'* (p68).

Spandler later argues that because of the context within which AMHPs make decisions, there is a risk that a person's presenting circumstances are considered within a bio-medical

perspective, as symptoms of illness, rather than understanding them within a social model perspective e.g. Tew (2011).

Service user/Survivor research has identified issues of coercion within mental health services as an under researched area (Rose et al 2008, Russon & Wallcraft, 2011, Gault, 2009, Hoge et al, 1997). Pilgrim & Rogers (2010) identify that historically service user or patient views have been dismissed or given insufficient weight within research and argue this is reflective of the general attitude of what they view as a paternalistic health care service. This viewpoint suggests that when exploring decision making under the MHA, research knowledge around the experience of being assessed, should be sought.

2.6 Models of Decision Making

The approach that this research takes is to explore AMHP practice in the context of decision making decisions, to contribute to the growing body of knowledge that seeks to shed further light on how decisions are made, the implications of this on practice and outcomes for people being assessed.

Professional decision making is a key area of interest within all health and social care roles. In the event of tragic events occurring, such as the death of children or incidents involving adults who are within the care of health and social care services, public inquiries scrutinise the decisions that professionals made and the rationale for those decisions being made. Commenting on 'best practice' for Social Worker's working within Child Protection the Munro report (D for E, 2011) advocates:

> *'Drawing on the best available evidence to inform practice at all stages of the work and of integrating that evidence with the Social Worker's own understanding of the child and families circumstances and their values and preferences' (2011, Para 6.34, p92).*

O'Sullivan (1999) explores tacit, or intuitive decision making, and analytic approaches to decision making, for example taking a formulaic approach or framework approach to decision making. His model is in relation to social work practice and he argues that:

> '*Decision situations in social work are unstructured in the sense that they consist of a potentially unlimited number of elements each impacting on the others in an uncertain*

> *way. By the very nature of unstructured situations, it is not possible to construct effective technical rules for determining the features of the problem and the best course of action. In such circumstances it is tempting for social work theoreticians to maintain that it is only professional intuition that can be used to make such decisions. At a time when professional intuition is being undermined with the introduction of bureaucratic forms of assessment (Howe, 1992), there is a danger that the argument becomes polarised between intuitive decision making and technical decision making. It needs to be recognised that analysis is not inevitably technical; together with intuition, it provides two equally valuable ways of thinking (R. Adams, 1995, p. 398) that are available to professional workers' (O'Sullivan, 1999, p84).*

Taylor and White (2000) discuss the ways in which professionals 'argue' a case and suggest that the types of language used, and the emphasis placed on certain elements of that case are intentionally applied in order to provoke a validating response from their audience. Whilst this example is in relation to child protection practice, this has relevance to AMHP decision making when considering the type and quality of information accessible to AMHP's charged with making a decision, which is then synthesised by the AMHP as part of the decision-making process.

This links into the ideas Taylor (2013) discusses around 'anchoring' – that being that an individual can quite quickly bias their thinking towards a particular conclusion and the risk that this can occur uncritically if reflection is not incorporated into practice. Taylor suggests that the risk of this occurring can increase during situations where a decision must be made quickly, and a practitioner draws upon knowledge gained from practice or 'what has happened before'.

Taylor (2013) places this in the context of coercion and the impact that this has on individuals. This is relevant to decision making given that coercion is generally understood as to persuade (an unwilling) person to do something by force or threat. How then does this relate to the service user's experience of being detained under the Mental Health Act or agreeing to informal admission. How much of an informed choice is this?

These ideas have relevance to this research as, in the context of a Mental Health Act assessment it is often the case that the AMHP receiving the referral has little or no prior

knowledge of the service user or their circumstances. By the time the referral is made for a Mental Health Act assessment the referrer must have good grounds for thinking that compulsory admission to hospital is a real possibility. I am interested in how the AMHP makes sense of the information that they receive and how this informs their decision making, bearing in mind the potential that the referrer is biasing their information to support their view. This is described by Houston (2003), when considering the moral discourse theory of Philosopher Jugen Habermas as 'strategic action', that being;

> *'In strategic action one actor seeks to influence the behaviour of another by means of threat of sanctions or the prospect of gratification in order to cause the interaction to continue as the first actor desires' (Habernas, 1990, p58 in Houston, 2003, p63).*

Taylor (2013), Taylor and White (2000) and Houston (2003) all suggest models of accounting for bias when weighing up information, these approaches all share similarities in that they encourage practitioners to apply an ethical framework to decision making that serves as a rationale for decisions made. The Guiding Principles can be considered one such framework but in practice AMHPs may also be influenced and guidance by reflection on a wider set of ethics and values which inform decisions.

Parallels can be drawn between Goffman's (1961) work on 'contingencies' and the findings of Hackett & Taylor (2013) who carried out research to explore the use of experiential and analytical cognitive processes in decision making within social work with children and families. They differentiate between the two types of knowledge social worker's draw upon when making decisions – that which they have learnt through their own practice experiences and that which they have gained through reference to research, most specifically evidence-based practice. They highlight a potential limitation of relying on experiential decision making as it can lead to the practitioner 'anchoring' themselves to one fixed point of view or failing to consider alternative outcomes. In relation to Mental Health Act assessments this model may impact on assumptions being made and decision biased by factors such as gender, diagnosis, race, or social class.

Peay (2003) explored practitioner decision making under the MHA, recording the discussions between medical practitioners and an Approved Social Worker when making decisions on the outcome of the assessment. She identified some decisions makers as following '*the*

*terminology of constraint; namely, the perception by the decision maker that he or she has no choice but to follow a particular course of action' (*Peay, 2003, p102). Having an awareness of trends in use of the Act can provide an evidence base to inform decision makers, ensuring that AMHPs have an awareness of the potential for discrimination and also the risk of failing to step back and explore a range of available options beyond the dominant discourse within the assessment. Campbell argues that this is essential if AMHPs aim to maintain their independent position within the assessment process;

> '*If mental health social workers fail to understand the potential for discrimination in the use of compulsory powers, then questions arise about the adequacy of the holistic knowledge that the professions claims in debates about the causes of, and solutions to, mental ill-health' (Campbell, 2010, p330)*

2.7 Emotion and Decision Making

Reflecting on her own experience of carrying out MHA assessments, Dwyer considered that:

> '*Amidst all the interactions, gathering of information, thoughts and practicalities, the most important person is the service user who is being assessed. There needs to be a mental stillness within the social worker to be able to focus and concentrate on this person, a still point amidst the 'sound and fury' (Dwyer, 2011, p346).*

Whilst specifically researching Social Work with children and families, Ferguson (2011) also notes the impact of the Social Worker's experience and knowledge and the ways in which this then manifest in their approach and practices. He also identifies team culture, inter disciplinary working and practitioner experience levels as factors that can also impact on the types of knowledge that are drawn upon in decision making. This strikes to the heart of the leap between theory and practice – whilst an individual may have a thorough and in depth knowledge of the law (be it The Children Act 1989 or Mental Health Act 2007) the way this plays out in a real life practice situation may be very disparate from the Code of Practice and the notion of 'best practice'. This approach to decision making links to practitioner skills and practice wisdom and capacity for critical reflection in their practice (Fook, 2002).

O'Sullivan (1999) explores the impact of practitioner emotional state on their decision making and the complexities around understanding this. Examples are given of strong emotions motivating practitioners, such as 'pride in a job well done (1999, p95). Quirk et al (2000) identify this sense of pride in the job as a finding around AMHP practice. However, emotions such as fear and anxiety or stress can lead to the potential for one aspect of a decision to take prominence. Research suggests that AMHPs work under pressure and the impact of how this influences decision making is an area that required further exploration.

2.8 Professional Discretion

Lipsky (1980, 2010) provides a theoretical framework that is useful in understanding how professionals make the links between policy and practice when working within a working environment of tension and stress. He proposes that workers will experience tensions between providing a service for service users and meeting the requirements of managers and explores how they exercise discretion in this task. Whilst some have critiqued the role of discretion within social care suggesting that as managerialism has increased this has marked the 'death of discretion' (Lymbery, 2000) others argue that Lipsky's work continues to have resonance for current public service professions (Evans & Harris, 2004). Arguably, the role of the AMHP has specific features which make this theoretical framework of relevance. Under English law, the decisions that AMHP's take regarding whether to section an individual under the MHA are independent of their status as an employee of either a local authority social services department or primary care trust.

The MHA Act Code of Practice (DofH, 2008) only provides guidance rather than legal duties, thus the Guiding Principles are not statute. During the MHA reform Eastman & Peay (1999) argued that; '*In this context, the Code arguably broadens and makes legitimate the clinician's discretion, it does not constrain it*' (p26). How then do the Guiding Principles operate in practice, have they been integrated into practice and what other knowledge sources do AMHP's utilise to gather and synthesise knowledge to make a decision? There is a scarcity of research exploring this.

Fulford (2011) considers the impact of a value base on practice. He outlines how shared values often underpin policy developments; a theme echoed by Heginbotham & Elson (1999)

who explore how public policy is influenced by law. These ideas have relevance when considering the impact of the Guiding Principles on the practice of professionals operating under the Mental Health Act. What status do they have and whose interests do they serve? One of the key elements Fulford (2011) explores in relation to use of the MHA is consideration of how practitioners can both respect autonomy and act in an individual's best interests and the tensions that this can lead to. This enters into a debate about care versus control in the social work role.

Evans (2015) explores the impact of ethics on decision making, in relation to the ethical codes that professions are required to adhere to. He proposes that this can lead to '*a set of law-like injunctions, rather than principles and aspirations'* which suggests that a focus on critical reflection can be diluted. He suggests that the application of ethics to practice *'encompasses dilemmas, conflicts, and intuitions and feelings as well as principles' (Evans, 2015, p87,* in Webber 2015*).* This approach to ethical decision making has some parallels with work from Banks (2018) around Virtue Ethics, which has relevance when considering AMHP practice as framed by the MHA Guiding Principles.

2.9 Empirical Research exploring the role of the AMHP

Observational studies of ASW/AMHP Practice

As regards an in-depth commentary on what it is that an AMHP actually does day to day, the only observational study of practice to date was carried out by Quirk et al (2000). They carried out a large-scale qualitative research project shadowing a range of MHA assessments across London. The research was carried out prior to the 2007 amendments so is in relation to the ASW role. However, given the similarities in the role in terms of function and duties, the research is of direct relevance to the AMHP role.

This was a comparative study which shadowed five teams within different boroughs in London over a period of 14 months. Assessments were observed in a range of setting including within service user homes and policy custody suites. A grounded theory approach was taken (Glaser & Strauss, 1967) to develop a hypothesis about what was occurring in practice with the findings suggesting that resources were an explaining factor in differences in the application

of the Act within different geographical areas. These are described as 'non-clinical and extra-legal factors' (2000). The research was carried out in the midst of the parliamentary reform of the Mental Health Act 1983 and Quirk et al (2000) warn that policy makers should invest time in considering policies around the allocation of resources and service organisation in addition to legislative change.

The research findings suggest six 'influences' on the possible outcome of a Mental Health Act assessment:

1. *How the teams organise MHA assessments*
2. *Resource Constraints*
3. *Support of 'the team'*
4. *Variations in local operational norms*
5. *Perceptions of conditions on the admission ward*
6. *Chance*

(Quirk et al, 2000)

The findings also indicate that certain biases were considered to influence decision making with some factors leading to bias towards detention and other towards not using the Act. These include:

- Work pressures leading to pragmatic decision making
- Risk averse cultures
- Difficulties accessing community services for people in crisis

Factors that are suggested as informing bias towards non-use of the Act include:

- Team support in 'risky situations

- Robust critical challenge from peers to account for decision making
- ASWs who prioritised the 'social worker' and 'therapeutic' elements of the role
- High bed rate occupancy and negative perceptions of inpatient ward environments

Quirk et al (2000) also considered the multiple roles the ASW enacted as they were observed prior to the assessment, during the interview and then what is termed the aftermath – what happens next. Key to the findings is how the roles are interchangeable so that the ASW was observed acting in these roles within the same assessment. These were defined as:

- Applicant
- Social Worker
- Care Manager
- Advocate
- Hate figure
- Supervisor/Trainer
- Therapist
- Policeman/executioner
- Bureaucrat
- Ongoing Contingency Manager
- Impresario

There is dissonance between many of these roles – therapist/executioner, advocate/hate figure and the researchers highlight the challenges that this places on the ASW. This research also interviewed people who had been assessed under the Act with the findings suggesting that the Social Work role was valued.

A recommendation is that alongside the ASW there should be a 'stage management' role to take some of the burden of all the other tasks away from the ASW:

> '*This research has indicated the time-consuming nature of MHA assessments, especially for ASWs. It has also demonstrated the considerable skills required to pull them off. ASWs evidently have a significant stock of knowledge that extends well beyond their knowledge of the Act itself. Also noted was the importance of being in a*

> *team comprised of supportive but challenging peers. Numerous ASW roles were observed, such as those of 'impresario' and 'ongoing contingency manager' (Quirk et al, 2000, p54).*

This research captures the nuances of ASW practice and serves as a source of knowledge of the realities of mental health practice, in terms of context, during that period of time. Significantly it also sheds light on the impact of context and values on decision making.

Fistein et al (2016) is a key paper in terms of its contribution to the development of research knowledge of MHA decision making 'in action'. One of only two studies to use observational methods, seven MHA assessment discussions were observed further to the interview with the person being assessed. The researchers note that this was over a 12 month period and that due to MHA assessments being a 'hard to reach' area of practice, the issues in gaining access to observe led to a limited number of assessments in the sample. Ethical considerations are not outlined, and the focus is on a very specific part of the assessment – the discussion between the decision makers as to the next step – whether eligibility for use of the MHA is met. The observations are followed up with interviews, including interviews with practitioners who were not observed. The focus of the interviews was around decision making in terms of the outcome of the assessment. However, a limitation of the study is the difficulties cited around recruiting AMHPs to take part in the interviews. Possible explanations include workloads and a lack of time to participate. The findings therefore are based on only one AMHP interview, alongside fifteen interviews with doctors. The insights around decision making from an AMHP perspective are limited to the seven assessment discussions (reported to have lasted around 20 minutes).

Fistein et al (2016) propose that for the participating practitioners, decision making around use of the MHA could be considered within a range of themes:

- Diagnosis
- Likelihood of response to treatment
- Risk assessment
- Decision making capacity

The suggest that this is a practical framework based upon criteria from the MHA but adapted for practice, and that views around a person's capacity to make their own decisions around admission impacted upon the perceptions of use of detention. This is conceptualised as 'soft paternalism:

> *Soft paternalism justifies limitations on liberty, for the benefit of the person being limited, provided that they are unable to make a choice that would be consistent with their own interests* (Fistein et al, 2016, p55).

They set out how the participants used this concept to justify their decision making. The authors, writing in the context of reform to the Mental Capacity Act Deprivation of Liberty Safeguards, and MHA reform are the case for aligning both Acts to reduce the apparent confusion between application in practice of the two statutes.

There was also discussion about the perceived 'difficulty' of decision making with 'straightforward' decisions being characterised as situations where there was a clear social stressor impacting on the person, which had a clear resolution. Other factors included:

- *an uncontested diagnosis of psychosis or severe mood disorder,*
- *a high probability of improvement if treated,*
- *impaired decision-making capacity resulting from difficulty understanding the need for treatment (as perceived by the clinicians),*
- *a high risk of harm to the patient or others, and*
- *the presence of significant distress or disability (Fistein et al, 2016, p54).*

More challenging decisions were characterised as involving risk, with findings exploring risk averse practice such as where decision makers erred towards making an application based on the perceived risk to the practitioners if an adverse incident occurred as a consequence of not detaining that person. An interview extract with a Psychiatrist summarises this – the view of the AMHP was not gained, which is a limitation of the findings:

> *Psy17: I think I'm being slightly controversial here, but I think the GP's concern here was more about covering our arses for any potential risk, rather than what was in the best interests of the patient. And I was more concerned about the long-term strategy*

> *of managing this person, the therapeutic relationship with the team and so on. So I think we all had slightly different takes on what would be the best thing to do in this case. I think eventually, again I'm being a little bit controversial, I think the GP's fears about a potential nasty incident communicated itself sufficiently to both the social worker and me, and we decided the safest option would be for him to be in hospital. (Fistein, 2016, p55).*

The findings summarise a view that the participants had merged aspects of the MCA and MHA including justifications for decisions based around best interests which is a criterion within the MCA rather than MHA. Whilst limited in terms of the wider AMHP decision making role the research does illuminate some aspects of 'street level bureaucracy' (Lipsky, 1980) in terms of how practice on the ground deviates from statute.

AMHP Skills

Bowers et al (2003) identified through interviews with practitioners the skills that Approved Social Workers (as was the role at the time of their research) use when carrying out a Mental Health Act assessment:

- Gathering and assessing information
- Organising
- Communication skills
- Keeping things calm

These findings perhaps support Hargreave's (2000) view that much of what is done by the ASW/AMHP is to 'oil wheels' – and perhaps this is reflected in the lack of research interest in how AMHP's actually go about making these decisions.

Trends in Use of the MHA

Hatfield (2008) uses statistical data to explore trends in use of the Mental Health Act prior to the amendments in 2007. This empirical research aimed to explore the demographics of people being assessed, pathways to assessment and outcome of the assessment. It was a longitudinal study over a nine-year period with data gathered from six Local Authorities who had made local arrangements to collect data as part of a MHA Monitoring system. 73.2 % of assessments were recorded amounting to data from 10, 961 MHA assessments. The

monitoring form used to collect data had been designed by the research team, increasing the reliability and validity of the study.

The findings give a comprehensive overview of rates of detention considered in relation to housing, ethnicity, diagnosis, gender, previous contact with services amongst other factors.

Statistically (p<<=0.001) single men were more likely to be detained than single women, and single people overall accounted for over half of all detentions. There was over representation of people described as African Caribbean in two local authorities. 39.2% of assessments occurred with people living in council or housing association accommodation with the second biggest group being owner occupied (20.4 %). 59.1 % of people assessed had a diagnosis of some form of psychosis. The findings also suggested an increased concern about drug and alcohol use accompanying mental distress, over the nine-year reporting period. 48.9% of referrals came from Psychiatrist and 4 % from a person's Nearest Relative. 73.2% of assessments resulted in detention. Risk to self was identified in 97.6 % of assessments and risk to other people recorded in 49% of assessments. 9.5% of assessments led to outcomes other than detention or other forms of care, just under three quarters resulted in detention.

> *The study suggests that the social milieu of those assessed and detained under the Act is one of disadvantage, as reflected in their housing and employment status. This confirms other studies that highlight the wider social inequalities that impact differentially upon those with mental health difficulties (e.g. Rogers and Pilgrim, 2003). People who live in disadvantaged urban areas are likely not only to experience material hardship at a personal level, but may also have limited access to 'social capital' (McKenzie and Harpham, 2006), including the informal bonds with other people and local sources of support that may buffer people when in crisis (Hatfield, 2008, p15).*

Hatfield (2008) proposes that ASWs are best placed to manage and understand the complexities associated with the experiences of poverty and discrimination to frame an understanding of crisis within a social model context. The findings also shed light on the link between social disadvantage, discrimination, and incidences of mental ill health, and perceptions around this.

A Reflection on the AMHP role

Dwyer (2012) reflects upon AMHP practice in response to Ferguson's (2010) work around Child Protection practice. One aim of the paper articulates views on the complexity of the AMHP role and highlights the gaps in knowledge around AMHP practice but also the implications of these gaps to individual's learning about social work practice:

> *'These two aspects of social work practice that are both at the control end of the care and control spectrum have similarities in regard to the basic details of practice. One such parallel is that the minute details of the work, the very stuff of what social workers do, right from receiving a referral for an assessment under the Mental Health Act, to the point where the service user is sectioned and admitted to hospital, or agrees a voluntary admission, or a 'holding' plan made – these myriad, complex and interesting details – are not sufficiently talked about, and not written about. Social work students reading about mental health law and policy will have no notion of how this is made real in practice' (Dwyer, 2012, p2)*

This paper is anecdotal from Dwyer's own experience as an AMHP, and is not based on empirical research, however, it is useful informing perceptions around the role of the AMHP within the limited literature. The conclusions further evidence the range of tasks and roles the AMHP takes on and the uncertainties in terms of the leap between statute and guidance as written down and practice, on the ground. Dwyer documents her own experiences of waiting for an ambulance to arrive in a person's home, dealing with hostility towards her, and the threat to personal safety from someone threatening to use a knife.

Bressington et al (2011) carried out empirical research to map the understanding of the AMHP role within a cohort of trainee AMHPs. The aim was to explore assumptions around different profession's suitability to undertake the role, within the context of nurses and occupational therapists being eligible to become an AMHP. They aimed to evaluate the impact of the training and practice elements of the AMHP training course on the trainees understanding. Five nurse trainee AMHPs and four Social Worker trainee AMHPs participated so the sample size was small. Data was collected via the use of concept maps at three points in the training, and semi structured interviews. Whilst the main insights from this paper relate to methods, with the authors proposing that use of this method demonstrated how knowledge of a topic developed through the training programme. The findings suggest that at the conclusion of

the training the learning from both cohorts was similar. Of interest for this literature review are data extracts from the findings that shed light on the trainee's views around the shift from theory to practice:

> *... I know the theory behind it, but the practice isn't there. I know I've got the knowledge, but I'm nervous about how I'm going to put it into practice... I felt that I'd done a lot of research and I'd done a lot of class work ...but I hadn't actually got it where it would all be working in the actual role, (Bressington, et al, 2011, p5)*

Since the research was designed and fieldwork began several more recent AMHP research studies have been published, that explore decision making.

Exploring the Least Restrictive Option

A qualitative study by Hall (2017) explores professional decision making where the outcome of the assessment was to refer the person for home treatment, i.e. not admitted. The research took place shortly before the AMHP role was introduced, so the research explored the ASW role. Of the 54 MHA occurring within the Health Service site nine assessments were identified where the ASW had requested home treatment as an alternative to admission. Semi structured interviews were undertaken with all parties – the service user, ASW and home treatment worker and a framework analysis was taken exploring how the approaches taken by the workers fit into a framework exploring the impact of negotiation, social crisis and practice models as factors leading to the outcome of home treatment.

Hall (2017) took a social constructionist approach to exploring how the assessing workers constructed the social situations of the individuals that they assessed. In terms of decision making, the findings suggest that the ASWs approached their assessment by making sense of the persons presentation in relation to their social circumstances whereas the home treatment workers were more focussed on identifying any presenting mental disorder. In terms of the dynamics between the assessors, the findings also suggest that the ASW took on a negotiator role in terms of gaining support or arguing the case for home treatment rather than admission.

> *'They need to negotiate a common understanding of mental illness with the HTT [home treatment team], agree a timescale for team decision-making, adhere to the resources*

available to the HTT, and ensure that the team feels secure with the decision-making of that ASW' (Hall, 2017, p10).

The study is small scale in terms of sample and deductive in its approach in terms of being driven by a model of understanding decision making in response to key themes from a literature review of existing knowledge around this field. It is not made explicit how this methodology aligns with a framework analysis approach to the research. The researcher was unable to recruit the people who were assessed to participate in the research so their view does not form part of the findings and the barriers to recruitment are not given. It does however contribute to an understanding of the ways in which the ASW approached decision making from a different model of understanding mental distress. The findings also shed light on the ways in which ASWs can seek to manage perceived risk in a way that is less risk averse than the other assessors.

Power and the AMHP role

Buckland (2014) used Foucauldian Discourse Analysis to explore use of Power within Mental Health Act assessments. Taking the position that '*Discourse therefore emerges at the point at which power and language intersect'* (Buckland, 2014, p4) this research focuses on the ways in which AMHPs articulate their positioning in terms of power. The research is situated within a very specific understanding of power and aims to explore the ways in which power is experienced and how it shifts in terms of how AMHPs make sense of the role. The findings offer insights into the ways that race, gender and social model understandings of mental disorder are understood by the AMHPs and the contradictory positioning in terms of talking about the role standing outside the 'system' whilst at the same time basing some decisions on dominant narratives around risk.

AMHP Identity

Leah (2019) developed the work of Quirk (2003) exploring the multiple roles of the AMHP in the context of how AMHPs identity. The range of roles that the AMHP holds alongside the statutory role were outlined for all the participants (ranging from Care Coordinator, to manager, to service commissioner), of whom there were ten.

Eight roles were identified and formed a framework for analysis of the data from qualitative interviews:

- Quasi-legal
- Detective
- Legal Enforcer
- Custodian of Social Justice
- Advocate
- Educator
- Mediator
- Therapist

Of note is the author's comments that across all participants there was an emphasis on the role of 'Custodian of Social Justice:

> *Caring for people, protecting individuals' human rights, and working with other professionals to ensure this was upheld was a core element of this role. The seriousness attached by participants of enacting the 'custodian of social justice' role was illustrated by all participants' narratives (Leah, 2019, p10).*

Leah notes the limitations of the study in the number of participants and makes explicit her position as an 'insider' researcher. The research findings outline the roles that can seem at odds with each other and identifies gaps in the knowledge that require further exploration. These are around the ways these roles are enacted in practice in terms of how AMHPs navigate the tensions between the roles, which can seem dichotomous and requiring further investigation to explore the nuance of this area of practice;

> '*For example, how AMHPs resolved the tension between the duty to legally coerce, whilst also protecting individuals' human rights, witnessed between roles of 'quasi-judge' and the 'custodian of social justice' was not examined within the study (Leah, 2019, p17).*

Morriss (2016) carried out doctoral research to explore the identity of AMHP seconded into Health Trusts. This study recruited seventeen AMHPs across England and took a qualitative

approach using interviews to explore the research question. The research sheds light on the challenges of the role and the perceptions of the participating AMHPs in terms of the 'dirty' nature of the work they carry out. This sociological concept, attributed to Hughes (1971) and first considered in relation to the ASW role by Quirk et al (2000) is explored further with Morris reviewing the literature and theorising that:

> '*Dirty work designations are more likely when the staff were not engaged in what they deemed to be 'proper' work, namely therapeutic work with service users. Thus, exercising social control was designated as 'dirty' because it deviated from therapeutic work. (Morriss, 2016, p4)*

Through analysis of the interview data Morriss explores the dichotomy between the social justice and empowering nature of social work values, and the compulsory powers an AMHP can use, discussing some of the contradictions seemingly apparent in the way AMHPs make sense of this:

> '*Although Andrew [AMHP participant] describes the act of detention as necessary at times and as aligned with his social work values, he also depicts some elements of AMHP work as dirty, notably the 'damage' done to service users. Additionally, there is an emotional, almost physical, impact on the AMHP of the 'guilt', 'mental power' and 'gravity' involved in removing someone's liberty' (Morriss, 2016, p7).*

The conclusions of the research outline how AMHPs seem to gain status from the statutory powers and for the participating AMHPs the role did not encompass so called 'dirty work'. The findings do however suggest that some aspects of the role can be considered dirty work, and the AMHPs did refer to the challenges of the role that had an impact on their emotions and risk of burn out. These factors included these included 'lack of beds, complexities of co-ordinating the assessment and the emotional labour involved (Morriss, 2016, p14). Morriss also notes that as observations of practice were not used this limits the insights gained from the data.

The sociological concept of 'dirty work' is further explored by Vicary et al (2019). They explore the term 'Role over or roll over' in terms of situations where the AMHP is left with the 'dirty work' of the assessment such as when an assessing doctor signs the medical recommendation

and then departs. Using qualitative methods and interpretative phenomenological analysis to make sense of the data, 12 AMHP participants (five Social Work AMHPS, five nurse AMHPs, two Occupational Therapist AMHPs) were recruited and data gathered via rich picture drawings and semi structured interview, with the aim of exploring the experience of carrying out a MHA assessment. This research found that the AMHPs experienced a sense of abandonment during assessments when they were left by the doctor and solely responsible for the rest of the assessment's coordination (e.g. arranging and waiting for transport). The findings explore dirty work in the context of shift, in terms of roles being passed on and the AMHP perceiving this as being left with the 'dirty work'. Vicary et al (2019) suggest that as there were few examples of the AMHP challenging the doctor in these situations, that they were legitimising this. This does lead to discussion around perceived power in the different roles, and perceived status. Vicary et al (2019) do flag that nurses tended to challenge more than other professional backgrounds, challenging the assumption that nurses are daunted by long established hierarchies within health care. This was a key concern cited during the debate around opening up the AMHP role to other professions.

Leah (2022) asks if the AMHP role is a 'Fool's errand', defined as:

> *'A foolish undertaking, particularly one that is nonsensical, or certain to fail, that involves an individual participating in a task which is known by that individual to be a waste of one's time or unwise but despite this knowledge is still carried out by the individual against their better judgement and in the knowledge that the action or the 'errand' is unlikely to be successful'* (Leah, 2022, p14).

Aligned to the consideration of AMHP practice as 'dirty work', Leah considers the role from a perspective of the potential futility of the role, given the pressures placed upon it.

The research explores the impact of resource pressures, primarily difficulties identifying inpatient beds, on the experiences of AMHPs, through use of interviews. Ten AMHPs were recruited over three health care trusts in the North West of England. They were asked to talk about their experiences of carrying out Mental Health Act Assessments, and the barriers and challenges they encountered when attempting to fulfil their role. Key findings suggest that relationships with other professionals and the resources available during Mental Health Act

assessments (e.g. alternatives to admission) were identified as the areas in which the role became problematic and outcomes could be detrimental to those that were being assessed.

Emotion and the Role of the AMHP

Quirk et al (1999) noted the emotional labour that was required of the AMHP 'performing the act', a theme picked up and explored in depth by Gregor (2010).

Gregor (2010) carried out interviews with twenty five AMHP's to explore their views on the transition to the new role and found that organisational pressures were a key issue identified as a barrier to carrying out the role and that if AMHP's were not adequately supported by managerial and organisational structures levels of stress and anxiety would increase. This was felt as not conducive to carrying out the AMHP role as Gregor argues that a higher level of practitioner emotional resilience is required to enable an individual to cope with the demands of the role whilst practicing reflexively and combining *'cognitive and emotional facets of personal development'* (p440).

In relation to the AMHP role, Gregor (2010) explored the impact of this kind of work on the mental well-being of the worker. Support and supervision from the team and management is identified as vital in ensuring AMHP's can maintain their emotional resilience and apply balanced and reflective decision making to the MHA assessment task.

This appraisal of the literature highlights that the majority of AMHP research involves small scale qualitative studies using predominantly interviews to elicit data. Quirk (2003) and Fistein et al (2016) are the only studies to shed light on MHA assessment decision making 'in vivo' via use of observational methods.

Themes that are identified within the research in relation to the AMHP role are around training and learning, developing practice experience, motivations to carry out the role, the relationship between power and the AMHP role in terms of status and links to sociological theory around dirty work. The research also identifies the myriad roles and responsibilities that AMHPs hold, within a context of uncertainty due to contextual pressures.

2.10 Outlining the research questions:

The AMHP role has distinctive decision-making powers within statute. As this review of the literature has demonstrated, these decisions do not occur in isolation and rather they are situated within a complex evolving context of mental health practice. They are asked to inform decisions with the values of The Guiding Principles but how does this translate to practice and how is this experienced by the people being assessed?

We can see therefore that there is a framework that decision makers are required to consider when making decisions under the Act but the Code does provide further guidance to stress that the 'guiding principles' should be used to inform not determine decisions. It also emphasises the impact of context on how they are weighted against each other and considered in each individual situation. Models of understanding decision making highlight the use of both tacit and analytic knowledge including the potential for bias and anchoring to inform decision making. Research from Fistein et al (2016) proposes ways in which practitioner values can inform decision making My research concerns itself with how this 'weighing up' is applied in practice, the bridge between policy and practice and if indeed practitioners do inform their practice by this framework. A review of the literature demonstrates that there is a scarcity of research exploring how AMHP's have begun to apply these principles in practice since the legislative changes of 2007.

Contextual factors sauch as trends in use of the Act, statistical evidence around higher rates in lower socio economic groups, age, race are all factors layered with the expectation that they bring a social model perspective to the assessment whilst arguably entrenched in a medical model led understanding of mental distress.

Decision making has serious life changing implications for people and the AMHP role in the system has not been subject of extensive research focus. This research aims to shed further light on this:

How do AMHP's make decisions during Mental Health Act assessments?

Aims:

- To explore how AMHP's generate and synthesise knowledge to make decisions.
- To consider if and in what ways decision making corresponds with the model of decision making outlined within the MHA Code of Practice's 'Guiding Principles'.
- To explore how AMHP's make the links between policy and practice in their work and what motivators drive these links.
- To identify barriers and aids to decision making within the context of a Mental Health Act assessment – such as the impact of time constraints, emotion and environment on decision making

The next chapter sets out how I went about designing the research to seek to answer the research questions.

Chapter 3: Methods

This chapter provides an outline of and rationale for the research theory and methods that were used to seek answers to the research question. The epistemological and ontological assumptions that underpin the research design will also be set out.

Qualitative methods, combining observations and semi structured interviews were used to elicit data, with fieldwork carried out accompanying AMHPs during their working day. Whilst taking this approach would necessitate careful navigation to gain ethical approval, as I had worked as an AMHP in my Social Work practice I was of the view that carrying out fieldwork would lead to a richness of data around day to day practice that would be less available via interviews alone.

Due to the observational methods used in this study and the focus on an ethically sensitive topic, a detailed account is provided of the journey that led to ethical permissions being granted, and a discussion around the ethical dilemmas presented. The specific research techniques are outlined, and in-depth information provided about the research access procedures, sampling strategy and accessibility. The validity and reliability of the research are also explored, considering the triangulation of data collection methods and the strengths and limitations of the approach taken. Reflections on the research process are threaded throughout this chapter but made explicit in a section considering researcher reflexivity and reactivity to the research process and the 'realities' of putting research design into practice in an 'in vivo' research setting. The chapter ends with a description of the analytical techniques employed and a rationale for this choice of method is provided.

3.1 Research Theory: Situating the research Epistemologically and Ontologically:

Cruickshank (2003, p. 5) states;

> 'We need to understand where we are coming from to make sense of how the conclusions we draw from empirical research are framed within particular ontological assumptions about how social reality is constituted'.

My standpoint is as a qualified Social Worker with a value base that has been informed by professional training in terms of anti-oppressive practice, rights-based practice, and social

justice. This sits alongside my personal values that align with principles around social justice, (Pickett & Wilkinson,2009)

Social Work knowledge, research, practice, and education draws upon a range of academic disciplines such as sociology, psychology, social policy, politics, health sciences and philosophy (Webber & Carr, 2015). Arguably Social Work research sits within a tradition of practice-based research with increasing focus on contributing to debates around evidence - based practice. It is within this mixed bag of disciplines that my own academic training has occurred, threaded through with what I can remember from an Undergraduate degree in Philosophy 25 years ago.

From the outset, the purpose of this research study was to produce original knowledge that is of practical use - to inform social work practice and to contribute to the field of AMHP decision making. I aimed to shed light on an area of decision making that occurs every day across England and Wales but usually behind 'closed doors' with little research scrutiny despite the outcome of those decisions having the power to deprive an individual of their liberty. With an interest in human rights I hoped to explore how these are upheld in everyday scenarios.

It was not the intention to productive definitive answers to the research questions, as arguably this is not the nature of the social world which is ever shifting and complex. This way of seeing the world seems most closely allied with critical realism (Bhaskar, 1978) – that by conducting empirical research it is possible to say something about the world and results of that enquiry that can be generalisable to some degree, but there is also acknowledgement that interactions between groups and individuals are socially constructed and context and culture dependent. (Pawson & Tilley, 1997). Use of this approach enabled me to explore my standpoint as a 'practitioner researcher' and the strengths and pitfalls of researching a topic that I am familiar with from both perspectives (e.g. impact on the research design through to analysis of the data). Houston (2010) advocates the use of critical realism as an underpinning philosophical position when undertaking qualitative research that explores social work practice.

Houston (2001) offers a critique of the post-modern turn within social work theory and practice and explores critical realism as an approach that reconciles some of the key debates.

One of the advantages of the approach for a field of practice concerned with social justice and anti-oppressive practice, is the approach to knowledge, with an acknowledgement that there are social structures that exist (such as power, law, discrimination) and that the ways in which society interacts with these structures can be empirically explored. Pilgrim (2014) explores the use of critical realism as a methodology to explore mental health practice. He argues that it enables critique of the dominant narrative driven by a diagnostic medicalised approach to understanding mental health.

Pilgrim (2014) explores the polarisation of positivism and social constructionism and proposes that critical realism sits within a middle ground that moves beyond these debates and thus has relevance for producing meaningful research in the field of mental health. He argues that critical realism enables research to be framed in such a way as to place emphasis on acknowledging, exploring, and challenging the dominant assumptions and narrative that underpin knowledge in this area of practice. He explores the relationship between critical theory and critical realism in this context:

> *'Critical theorists and perhaps Habermas in particular, recognised that dominant positivist narratives potentially play a role in ensuring the continuation of status quo explanations of social phenomena. Critical realists for their part articulate this position by suggesting that looking beneath the surface and developing explanations for what causes things to happen is potentially emancipatory in that it can challenge and ultimately help change dominant narratives and discourses, something which positivistic approaches often fail to do or are not concerned with doing in the first place.* (Wilkinson, 2019, p2)

Teater et al (2017) argue that underpinning Social Work with Evidence Based Practice enables the profession to demonstrate to policy makers more robustly and most importantly the public, the valuable contributions the profession makes to social care. This perhaps demonstrates the ways in which practitioners are encouraged to negotiate an understanding of the world combining what can be learnt from the 'real world' that exists and the contextual understanding of individual situations – the dualism that is supported by taking a critical realist approach. Pease (2012) explores these dilemmas for Social Work practice and research

and suggests that rather than staunchly maintaining an objective universalist or subjective relativist position, research should seek to bridge the gap between the two paradigms.

In summary, an understanding of critical realism has informed this research in terms of informing the epistemological positioning of the research. It does not claim to sit purely within this methodological approach but borrows from the key principles that underpin it as a rationale as to why the findings might be relatable and relevant to all AMHP practice.

3.2 Values Based Research

A key motivator for me is the impact that research can shed light on social issues. Having worked in AMHP practice I have observed and been a part of the power that the MHA has over individuals who have their liberty deprived. Longhofer & Floersch (2013) write from a critical realist perspective and set out the case for the ways in which research should be informed by values and how this can be enacted in terms of reflexivity to the research process:

> 'Indeed, it could be argued that truly reflexive practice and research on practice is guided by this inevitability and by the creative tensions between the normative and the descriptive. In short, reflexivity is not only the hoped-for practice outcome. We hope, too, that our scientific practice is reflexive and by that we mean that values are fully engaged as objects of inquiry in their own right and that methodological choices are informed by those value commitments and recursively explored in the research process' (Longhofer & Floersch, 2013, p4).

The research questions and research design aim to explore values-based practice and are motivated by a value base that promotes social justice.

Tew et al (2006) propose a set of principles to inform the value base of social research within mental health with one principle being to ensure research has an emancipatory purpose:

> *Emancipatory purpose – how will research produce evidence and theory that can enable service users and carers to:*
>
> *• have a greater awareness of their situation so that they can make informed decisions and choices*
>
> *• have more control over the direction of their lives*

- *participate more in social, economic, and political life and can enable them, in conjunction with practitioners and members of the wider community, to:*

- *challenge stigma, injustice, and social exclusion? (Tew et al, 2006)*

3.3 Ethical Considerations informing choice of methods:

Initial considerations around the research question included how ethical it was to include people who had been assessed under the MHA as research participants. For example, they may feel they already have more than enough of their time taken up with talking to professionals and so may be reluctant to participate. The process of being assessed under the Mental Health Act is potentially disempowering and traumatic – this may lead to individuals being motivated to talk about their views in relation to this but it could also mean that potential participants choose to leave these experiences in the past and not revisit them. There was the potential that service user's may be guarded, perceiving me as a professional who is part of 'the system' and give me an edited or angry version of events.

The research proposal and later the research protocol was been reviewed by a service user and advocacy group who fully supported the aims of the project and the methods used (see Appendix 1). Support was also gained from AMHP practitioners and the Head of Collaborative Research at the proposed NHS research site. Whilst there were ethical implications to carrying out research that included observations of practice, given the lack of research evidence that explores what occurs during a MHA assessment and given this event has such an impact on the human rights of an individual it is a research worthy topic (see Stone et al, 2019).

Observations of social work practice 'in the field' are also advocated by Ferguson (2014) who notes that little research focus has been given to what actually occurs in social work practice between practitioners and clients, with the majority of observational studies taking place within the office environment rather than in the community, within service user's homes.

3.4 Decision to use Qualitative Methods

The research utilised observations, field notes and interviews to generate qualitative data suitable for analysis by qualitative methods.

There were two components to data collection:

1. Observations of day to day AMHP practice including accepting referrals for MHA assessments, coordination, and attendance at the assessment. Data was captured through use of field notes.

2. Semi structured interviews conducted with AMHP's and people with lived experience to explore how decisions are made.

Webber & Carr (2015) argue that the polarisation of research methods is unhelpful in the context of Social Work research as the different types of research knowledge generated by quantitative and qualitative methods can be useful in providing a broader understanding of the social issues it aims to shed light on. Consideration was given to a mixed methods approach to explore the research questions. For example, an online survey with free text could explore AMHPs attitudes towards the Guiding Principles would have enabled access to a large cohort of AMHPs and would have generated a large data set around attitudes. These findings could then be analysed as a distinct data set alongside the observation and interview data. However, as the intention of the research was to explore the nuances of every day AMHP practice and decision making, and what underpins this', a purely qualitative approach was adopted. The research was inductive to some extent although informed by research questions. Whilst I considered taking a theory driven, realist evaluation approach as outlined by Pawson & Tilley (1994) (evaluating a framework of decision making to understand decision making), the literature highlighted significant gaps in research knowledge about the nature of AMHP decision making, the contexts within which they occur and the nuances of practice. The use of an inductive qualitative research methodology aims to fill these gaps and contribute to new knowledge about decision making and the contextual factors that influence this.

3.5 Case Study Approach

A qualitative case study approach was taken to explore the research questions. This approach arguably 'permit(s) the evaluator to study selected issues in depth and detail (Patton, 1990,

p13). It also enables a breadth of focus to the study, to allow the data to drive the research, inductively. This approach is in line with both the nature of the questions and the ontological and epistemological assumptions that underpin the research as there is opportunity to consider empirically the contexts that drive decision making.

> *'Case studies generate context-dependent knowledge which is an appropriate form of knowledge base in social sciences and disciplines based on observation and understanding of human behaviour and interaction in context' (Widdowson, 2011, p25).*

The focus of the research was decision making in AMHP practice and the case is the research site within the observations and interviews were carried out. Whilst case study approaches can be criticised for their lack of generalisability the 'So what?' question, Flyberg (2006) defends the use of case studies as a means of contributing to the generation of knowledge. Flyberg suggests that as learners, humans base their understanding on seeking information on a range of cases and examples which, when considered alongside a range of other sources of knowledge, enable us to know something about a particular topic or field. These research findings aim to say something that is generalisable across all areas of AMHP practice at all times, with one aim of the research questions and methods being to generate themes that have relevance to the research focus – how AMHP's make decisions. These themes may then generate questions for further research alongside highlighting issues and trends that could prompt reflection on practice for individuals, in response to the findings. In this way the research aims to be of value to both theory and practice.

Peay (2003) outlines the pros and cons of 'in vivo and invitro' research methods, i.e. being research conducted 'in life' rather than in a 'laboratory'. Her own research exploring how professionals make decisions during Mental Health Act assessments took a vignette case study approach and she advocates this approach as a means of placing greater controls upon the research and the data that is generated. Peay highlights some of the ethical and methodological implications of carrying out 'in vivo research into professional decision making;

- Cost – time, resources and financial
- Difficulties in accessing decision makers

- The decision-making process may be intermittent and infrequent
- The recollection and explanations for their decision making may be affected by the passage of time if it is not possible to interview decision makers soon after a decision has been made
- Some research is 'barred' in practice due to issues with access
- Data collection must be extensive to control for the many exogenous variables that may complicate these studies (Peay, 2003, p122)

As will be detailed later in this chapter when discussing the ethical implications of carrying out this research, it was necessary to address the points raised by Peay (2003) plus the other dilemmas highlighted, when designing this research and gaining favourable ethical opinion. As has been referred to previously, this PhD has been funded by an Economic and Social Research Council studentship via the Social Work pathway that aims to invest in social work research. Having the space and time of post graduate research study to devote to designing and carrying out this research enabled it to happen as it has been a time-consuming process given the obstacles and hurdles that had to be overcome in order to arrive at the point of collecting data.

3.6 Ethnographic methods:

Ethnography is defined as:

'A particular method or set of methods which in its most characteristic form involves the researcher participating overtly or covertly in people's lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of research (Hammersley & Atkinson, 2007,p1).

Using observational methods I had the opportunity to reflect in action on what was occurring during an assessment (Schon, 1984) aiming to capture something of the intangible nature of an assessment – the emotions that underpin it, the pressures (both seen and unseen) on all the parties involved. Nuances such as a GP looking at her watch and wanting to hurry the assessment along, the AMHP without a mobile phone signal and having in the back of his mind

that he has his child to collect from the after school club and no way of letting them know he will be late. I could case my gaze to shed light on how knowledge is generated, balanced and a decision then made within these contexts.

Pithouse (1998) carried out observations of social workers based in child care settings over a period of 12 months with a key aim to make the 'invisible trade' of social work visible by producing empirical research to shed some light on the activities that take place beyond doors often closed to researchers, 'in vivo'.

> *'Social Workers, like all of us, must establish the bases for their activities. They routinely do so through the medium of talk. They, like most of us, are not professional theorists of the social structure, nor for that matter of the psychological structure of group and individual processes. It is in this respect that oral traditions are typically bereft of a technical or medical vocabulism. They do not employ some arcane argot; like most of us they live in a broader collective that the work setting. They apply the language of their broader membership to express the common-sense theory of doing social work' (Pithouse, 1998, p158)*

A statement from Hammersley & Atkinson (2007), describing the merits of ethnographic approaches, provide further justification for use of observational methods to gather data to answer the research questions;

> '*What is happening here, then, is a significant development of the ordinary modes of making sense of the social world that we all use in our mundane lives, in a manner that is attuned to the specific purposes of producing knowledge' (Hammersley & Atkinson, 2007, p17)*

By using ethnographic methods within a case study site (Brewer, 2000), complimented by in depth semi structured interviews, a depth and richness of data could be gathered that would not be possible if interviews were the only method, as they would report on an event through the lens of time having passed, reflection and hindsight impacting on what is reported or felt relevant to mention by the participant at that moment in time. Patton (1990) notes that when some aspects of practice become more routine 'they may cease to be aware of important nuances that are apparent only to an observer who has not become fully immersed in those routines' (p204). As my identify as an AMHP was known to practitioners there is a risk that

through use of interviews alone they may assume shared knowledge and so something of the nature of how they make decisions in practice could be lost (see Pithouse, 1998)

> '*For researchers, the closeness of the case study to real-life situations and its multiple wealth of details are important in two respects. First, it is important for the development of a nuanced view of reality, including the view found at the lowest levels of the learning process and in much theory, that human behaviour cannot be meaningfully understood as simply rule-governed acts' (Flyberg, 2006, p222*).

Field notes were written during the observations, noting what happened during the assessment from the point in time that a referral was received by the AMHP, to the end of the assessment. Reflective memos were added soon after each observation to begin the analysis of the data whilst the event remained fresh in my memory. Hammersley & Atkinson's (2007) guidance was followed on managing the vast amount of field notes that were generated during observations with the additional aim of supporting the analysis and strengthening the quality of the research findings.

Hammersley & Atkinson (2007) provide useful advice on ways to manage the vast amount of field notes that are generated during observations and how this organisation strengthens the quality of the research.

> 'These techniques play an important role in promoting the quality of ethnographic research. They provide a crucial resource in assessing typicality of examples, checking construct indicator linkages, searching for negative cases, triangulating across different data sources and stages of the fieldwork, and assessing the role of the researcher in shaping the nature of the data and the findings' (p157).

In advocating observational methods to shed light on research practice Ferguson states;

> 'Reclaiming this lost experience of movement, adventure, atmosphere and emotion is an important step in developing better understandings of what social workers can do, the risks and limits to their achievements, and provides for deeper learning about the skilled performances and successes that routinely go on' (Ferguson, 2010, p1102).

Use of these methods enabled data to be generated that could be triangulated to produce research knowledge. The aim was to produce findings that are not just an account of what

AMHPS do (which, as an AMHP I was familiar with), but a robust method of making sense of this information from a research perspective. Personally, this would lead to a shift from practitioner knowledge to researcher knowledge but maintaining relevance to practitioner due to this dual approach to seeking answers to the research questions.

Guidance was also taken from the Mental Capacity Act Section 32 (3), regarding carrying out research with people who are unable to give consent and the requirements of the ESRC framework for research ethics (2012). The initial application to the Social Care Research Ethics Committee had used this legislation to design the research as my perspective was that the person would be likely to lack capacity to understand the full implications of participating in research on the day that they were assessed under the MHA. However, the Ethics Committee took a different view and required me to gain consent to use the observational data *after* the event. This was unexpected as suggested their view was that the observation in itself was not research, rather it was the subsequent use of the data that defined at which stage the fieldwork became research.

3.7 Observations of Practice:

Observations of practice took place within a range of settings within which AMHP's are based (within the case study site) such as multi-disciplinary Community Mental Health Teams and out of hours services that are staff solely by local authority staff. Based on my working knowledge of the AMHP role it was my assumption that this approach would produce a broad range of opportunities to observe assessments within the community including in service user's homes and on hospital wards and police custody suites.

Designing the interviews:

The interview schedules for both AMHPs and people who had been assessed were designed to prompt a reflective discussion about an event we had both experienced either as researcher (me), the AMHP carrying out the assessment, or the person who the assessment was for. The comprised open questions and prompts that also provided scope for the discussion to lead in unexpected ways rather than being narrowly confined to a rigid interview schedule. The questions were designed to maintain a focus on decision making, for example, from the AMHP interview (Appendix 2):

- Why did you decide to become an AMHP?
- Looking back at the recent assessment, what are your overall impressions of what went on?
- What went well?
- What didn't go so well?
- Would you have done anything differently with the benefit of time to reflect on what happened?
- What types of knowledge did you draw upon during the assessment to help you make a decision? (Prompts – tacit, case law knowledge, evidence based/research-based knowledge).

I considered models of professional reflection (e.g. Gibbs, 1988, Schon, 1991 and Johns, 2000) that I used in practice when supervising Social Work students and borrowed from these approaches to underpin the interview with prompts designed to aid reflection.

I drew upon my Social Work skills to set the scene, form a rapport, and promote an environment where the participant might feel able to speak openly about the topic. I used active listening skills including use of silence to allow time for thoughts to germinate and meaningful space to think through responses both my own and the participants (Green, 2008).

The same approach was taken with the interview schedule (Appendix 3) for people who had been assessed under the MHA. Further to the initial NRES application this was amended to reflect feedback and requirements from the committee. It was also approved by the service user network research group. The full version in within the appendix but example questions include:

- Please tell me a little bit of background as to why you are, how long you have had contact with MH services etc.
- What do you remember about your recent assessment under the Mental Health Act?
- What are your main thoughts about that day?
- Why do you think you were assessed under the Mental Health Act?
- How were you involved in the decision making during the assessment?
- How were your views and wishes taken into account?

The questions were designed to explore how the Guiding Principles of the MHA were experienced (or not) during the assessment as the questions related to the values that underpin these Principles.

3.8 Early considerations around access and recruitment:

As a practitioner researcher I was well placed to access to research participants due to links with local authority workers and knowledge of the management structures that AMHPs are subject to. This enabled the identification of gatekeepers and ensured that discussions could take place at the outset of the research design to determine the feasibility of access to research participants. Prior to seeking ethical approvals, I liaised with the key gatekeeper in the research site and was able to establish early on that there was a 'will' to support the research using observational methods of 'real life' Mental Health Act assessments. I was also able to consult with service users/survivors to discuss the research project and gain feedback from this stakeholder group. Having received positive feedback and support to explore this area of practice boosted my morale and motivation when overcoming the various hurdles that had to be met prior to the fieldwork being carried out. Having an understanding of the duty rota system that the majority of AMHPS tends to operate within I was also able to plan for the logistics of recruitment and setting up not only the observations but also following up with the interviews for both AMHPS and service users. Having an 'insider' knowledge of mental health services helped towards ensuring the research methods were realistic and achievable. This insider knowledge also assisted the successful ethical approval process and planning recruitment and access.

3.9 Sampling and Recruitment Strategy

The case study site was selected using an information orientated selection method (Flyberg, 2006), that being that the research site chosen was likely to produce a range of learning opportunities about what goes on in practice. This case study site lends itself to the answering of the research questions as the chosen Local Authority operated across a range of urban, suburban and semi-rural sites and had a large population (over 500,000 according to the 2011 Census returns) and so allowed opportunity for observations of a range of assessment settings. Whilst it was not the intention of the study to claim that the case study site was a representative sample, AMHP work is varied and complex and the case study site was chosen

to reflect the context within which all AMHP's operate. There was also the pragmatic choice of site as it needed to be geographically accessible for me to spend time carrying out the fieldwork and as it is more time and cost effective to carry out the research more locally.

The case study site allowed observations of practice in a range of settings within which AMHP's are based (within the case study site) such as multi-disciplinary Community Mental Health Teams and out of hours services that are staff solely by local authority staff. These settings were likely to produce a broad range of opportunities to observe assessments within the community and on hospital wards and police custody suites. The case study setting also facilitated observations of AMHP's positioned with a range of working environments including those 'integrated' and those 'de-integrated' with NHS staff, which perhaps does have some bearing on the types of approaches that are used by practitioners.

All AMHP's who were currently employed and participating in the AMHP duty rota within the Local Authority case site were invited to participate in the study with a total of up to 10 being recruited. At the time of recruitment to the research there were around 45 full time equivalent AMHP's practising in the case study site, totalling 75 individuals. The aim at the outset was to observe up to 10 Mental Health Act assessments with a limited number of 10 AMHP participants. This number was determined to ensure sufficient data was gathered to explore a range of assessments and circumstances and was limited to ensure that the analysis of the data could be carried out at a level to ensure the richness and nuance is explored in depth.

The participant numbers were limited as although employed by a Local Authority, AMHP's are usually based within multi-disciplinary teams with NHS colleagues and alongside being on a duty rota for Mental Health Act work, also carry out non statutory work. As informed consent would be required from wider team members to permit observations to take place within these shared work bases, logistically it would not be possible to seek this from ten separate teams - therefore, through collaboration and liaison with the potential participants, the AMHP's who were recruited ideally would be based in 2-3 different teams. This decision was taken as it was felt that the approach to recruitment would not impact upon the nature of the assessment received as these occur randomly from the wider geographical area. There was the potential for a further 30 co-worker participants (based on 10 workers per team) to

be involved in the research taking this approach to recruitment, although research data would not be collected in relation to their practice.

Service user participants would be included if they were referred for assessment by a participating AMHP and the inclusion criteria was met (outlined below). The service user would be invited to be interviewed about their experiences of being assessed within approximately 1 month of the assessment taking place if someone who knew them well could confirm that they were able to give informed consent at that time. The total number of service user participants would be up to 10.

Total sample size: 20

The research aimed to observe 10 Mental Health Act assessments, gathering field note and audio recorded data.

The sample to be comprised of:

- Up to 10 AMHP Participants
- Up to 10 service user participants
- Up to 10 post observation interviews will take place with the Approved Mental Health Professionals participants who carried out the observed Mental Health Act assessments.
- Up to 10 interviews will be carried out with the service users whose assessment under the Mental Health Act was observed.

AMHP participants were identified via the Lead AMHP for the Local Authority who held contact details for all AMHPs operating in that area. I also attended the AMHP's team meetings to provide information about the research and follow this up with email to each AMHP containing the participant information sheets (Appendix 4). Once an AMHP indicated via email or telephone that they were interested in participating they received a consent form to sign and return. I planned that if more than 10 AMHP's consented to participate a pragmatic decision would be made to select the 10 participants based on their team base.

AMHP Co-workers would be identified by requesting via the participating AMHPs a list of contact details for their team members. I then emailed a copy of the co-worker participant

information sheets (Appendix 5) to all team members and attended a team meeting to provide verbal information about the study and to answer and questions that may arise.

Service User participants would be identified when a referral for a Mental Health Act assessment is received by the participating AMHP.

Inclusion Criteria:

- AMHP practitioner employed by X and participating in the duty rota for carrying out Mental Health Act assessments.
- Service user who gives verbal consent to have their assessment observed and later gives informed consent to the use of this data.

Exclusion Criteria:

- An AMHP who is no longer practising in X.
- A service user who does not give verbal consent or gives verbal consent to be observed but chooses not to consent to the use of this data being used for the research.
- A service user who is under the age of 18.
- A service user who lacks the capacity to give informed consent to either stage of the research.
- A service user who verbally objects to the researcher being present during the assessment.
- A service user who has a long-term cognitive impairment such as a diagnosis of dementia which makes it unlikely that they would regain capacity to consent to participate.
- A service user who becomes distressed by the research process.
- Any participant who withdraws their consent to participate.

3.10 Gaining Ethical Approval – the National Research Ethics System and Social Care Ethics Committee

By far the greatest challenge to carrying out this research project was the ethical implications of the use of the methods employed. At the outset of the research design several individuals – a psychiatrist, a Social Work academic, some AMHP practitioners shared their views that I would 'never get ethical approval to do that' when I spoke about my intention to observe Mental Health Act assessments for the purposes of research data collection. However, Harry Ferguson, a Social Work academic who has written extensively and advocates for the use of observational methods in his exploration of Child Protection practice asked me: 'why not? Thus began a journey that took over 12 months from the point of submission of the NRES form, to the first day of fieldwork.

Stone et al (2019) of which I was a co-author, outline the challenges of gaining ethical approval to carry out research into AMHP practice given the context within which they practice, across Local Authority and various NHS sites. This is cited as a barrier to carrying out AMHP research and an argument presented as to why this is of concern in terms of the potential lack of scrutiny upon a role that makes such key decisions in an individual's life:

> *'The key issue here is that the current multisite procedural ethical governance processes can act as disincentive to designing and undertaking a study that focuses upon the AMHP profession. AMHP work happens away from public scrutiny as the assessments which are undertaken occur in people homes or institutional settings. Although arguments for privacy and upholding dignity are convincing as to why this should be the case, research offers the opportunity to illuminate AMHP practice and provide some form of evaluation where otherwise none would exist. Recent UK governmental statements have expressed concern about the over use of the mental health legislative powers being used to remove the liberty of people who are experiencing mental disorder and at risk, but the opportunity to offer evidence is diminished through problematic procedural ethical arrangements (Stone et al, 2019, p12).*

The main ethical issues for this project related to the involvement of human participants and the potential risk of harm that the study could place them under. The study aimed to interview mental health service users who, due to this status, were regarded as vulnerable (ESRC, 2012).

The plan was to involve people with lived experience in two ways – during the observations of practice and when invited to talk about their experiences of being detained via a semi structured interview. As the research involved NHS patients and Local Authority service users, it was necessary to seek approval via the Health Research Authority National Research Ethics Committee. I specifically took the application to the Social Care Research Committee which required a trip to their office base in London to present the case to the committee. The study gained favourable opinion on the 22nd May 2015 (REC ref no: 15/IEC08/00). The final application was accompanied by a large volume of supporting documents including six different participant information sheets dependent upon the circumstances of recruitment and consent (please see appendix).

As the AMHP participants were employees of the Local Authority, appropriate approval was required to involve these participants as per local R&D policy. In addition, R&D consent was also required via the NHS Trust within which the AMHPs were operating, as people being assessed who I hoped to recruit, were NHS patients, AMHP co-workers may be NHS employees and the observations were likely to be taking place on NHS property. This led to a long journey of navigating the University ethics procedures but also gaining approval from the Social Care Research Ethics Committee via the National Research Ethics System. It also led to confusion from the University R&D team as there were no clear procedures in place clarifying what ethical permissions were required from the Local Authority as the employees often worked within an NHS setting. Logistical challenges prior to access led to substantial delays to the research timeline and highlighted potential barriers to carrying out research in more complex areas of practice. There were points in the journey when I considered abandoning the plan and redesigning the research exploring a research design that would be less likely to encounter such challenges. However, this would have meant losing the observational element of the study which I felt was too important to jettison – and so I persevered.

The key issue was how to gain informed consent to participate in the research. For example, when preparing the ethics application I considered that for stage 1 of the research, the interviews, advance consent would not be possible to gather from the service user participants if the assessment was unplanned as is often the case, and so careful thought was

required to manage this issue ethically. Quirk et al (2008) carried out a similar study using observational methods to explore decision making in the context of Mental Health Act assessments although this was prior to the amendments to the Act in 2007. Verbal consent was deemed sufficient from the service user participants in this study and no reference is made to the issues in the authors summary, around gaining informed consent. In addition, a similar study gained ethical approval to be carried out in South Maudsley NHS Trust, commencing in 2012. A film crew from Channel 4 shadowed AMHPs' during Mental Health Act assessments. This included filming participants who were unable to give consent at the time for filming to take place. Filming took place after consultation with the care team who were asked to give an informed opinion as to the appropriateness of the film crew being present. The crew returned to the service user once they had capacity to consent and if they refused then their film was not broadcast.

Whilst initially I drew upon guidance from the Mental Capacity Act 2005 (DoH, 2008) to inform involving participants who may lack capacity to consent, as the NRES felt it unnecessary the final ethical approval around gaining consent took a similar approach to the Channel 4 documentary. Consent would be sought at a later date from people who had been observed at their MHA assessment with the requirement to consult with the person's care team prior to an observation taking place.

Participating in the research did not alter the care or treatment that the individual being assessed would have otherwise received. There was a risk that service users may feel coerced to participate but this was reduced and managed by informed consent being reviewed at different time points in the research (via seeking verbal consent prior to the observation, gaining informed consent after the observation and seeking consent again prior to the interview).

3.11 Negotiating consent

Due to the nature of ethnographic research, that being that it seeks to explore 'real life' situations as they occur in 'real time' there are inherently ethical challenges to anticipating and therefore gaining informed consent for all possible events whilst carrying out field work. Murphy and Dingwall (2007) explore these issues in depth and suggest that issues around

consent are constantly being negotiated and re negotiated between researcher and participant.

> 'Typically, at the start of such research, consent is both tentative and limited and the researcher's access to sensitive aspects of the setting may be restricted. Over time, as the trust between researcher and hosts develops, access may be granted to previously restricted areas or interactions' (Murphy & Dingwall, 2007, p8).

Service Users: There are issues with gaining informed consent due to the often-emergency nature of a Mental Health Act assessment and it being unreasonable and potentially coercive to gain this on the day of the observation.

The inclusion and exclusion criteria outlined the situations when an observation might not be appropriate, for example if the person being assessed was unlikely to have the capacity to give informed consent such as an individual experiencing an advanced stage of dementia. Prior to seeking consent to observe an assessment I outlined how a discussion would take place with the participating AMHP as to the appropriateness of this, considering risk issues amongst other factors. I anticipated that there would be three different approaches to gaining consent based on three different scenarios:

1. If the participating AMHP is aware of an assessment with at least 48 hours' notice and if it is appropriate to do so based on the inclusion and exclusion criteria, the person due to be assessed would be given the participant information sheet and given at least 48 hours to consider giving informed consent for their Mental Health Act assessment to be observed and also to be audio recorded. They would then be contacted further to the assessment to check that consent is still given and to invite them to be interviewed (See Appendix 6).

2. If the assessment is unplanned then verbal consent for the observation of the assessment would be sought, and to audio record it, prior to the assessment commencing. If this was provided, they would be given a brief information sheet at the end of the observation to outline the research and to ensure that they had my contact details. I would then liaise with the assessed person's care coordinator to determine an appropriate time for them to receive the full Participant Information Sheet and to consider giving informed consent to use of the

data gathered prior and during their assessment and/or to be interviewed about their experience of being assessed (See Appendix 7).

3. If a person being assessed chooses not to have their observation observed but data was gathered during the observation of the AMHP carrying out work prior to the assessment, informed consent would still be sought from the person being assessed as this is information about them. I would then liaise with the assessed person's care coordinator to determine an appropriate time for them to receive the full Participant Information Sheet and to consider giving informed consent to use of the data gathered prior to their assessment and/or to be interviewed about their experience of being assessed (See Appendix 8).

Family and Friends – as it is possible that the person being assessed is accompanied by a friend or family member, it would be necessary to gain their consent to observe proceedings. They would be asked to provide verbal consent on the day including a request being made for permission to audio record the assessment. They would then be given a Participant Information Sheet to consider giving informed consent for any data gathered during the assessment that includes their comments, to be used in the research.

Although I was unable to recruit any participants who had been assessed, had these occurred I had taken steps to manage any distress the questions may lead to, with sensitivity to the personal nature of the research topic. Built into the research design was respect that the participants may choose not to answer or talk about some aspects of their experiences. In addition, if during an interview a participant became distressed or upset, they would be asked if they wished to stop the interview or have a break from the interview.

To mitigate risks and offer support, service user participants would be given information about the Independent Mental Health Advocate service (if the assessment had led to their detention under the Act). Participants would also be given information about Patient Liaison and Advice services in their area should any concerns about practice arise that they wished to pursue. They would also receive contact details for the researcher so that if there were any follow up questions after the formal interview they could make contact and be provided with relevant follow up information as required to aim to alleviate any anxieties they may have about participation.

Throughout the research process all participants were reminded that they were free to withdraw consent at any time.

In terms of the risk to the AMHP participants, the primary issue identified was the burden on their time of participating in research at both the observation stage and the interview. As a workforce working under pressure it was possible that being observed and having to accommodate me as a researcher could add to these stress loads.

It was also necessary to consider and identify issues around consent and risk in relation to the AMHP co-workers at any team within which the AMHP is based. They were informed of the study and asked to give informed consent to the researcher being present for any observations they were also involved in. Given that the observations research would take place within the AMHP's working environment, the potential for individuals who have no prior knowledge of the research to become part of the observation, was identified. For example, co-workers such as General Practitioners, police, and ambulance crew. They were given information about the study and asked me to give verbal consent for the me to be present and to return signed consent forms after the observation had taken place. It was also possible that friends or family members of the service user who is being assessed would be present. This scenario did not arise but plans were made that in the event of others being present at the assessment, they would be asked to give verbal consent to the observation and given Participant Information Sheets and a consent form to return after having at least 24 hours to consent to the use of data collected from an observation from which they became a part. The co-workers and family/friends of the service user were not considered research participants as their role in the decision-making process is not the focus of this research.

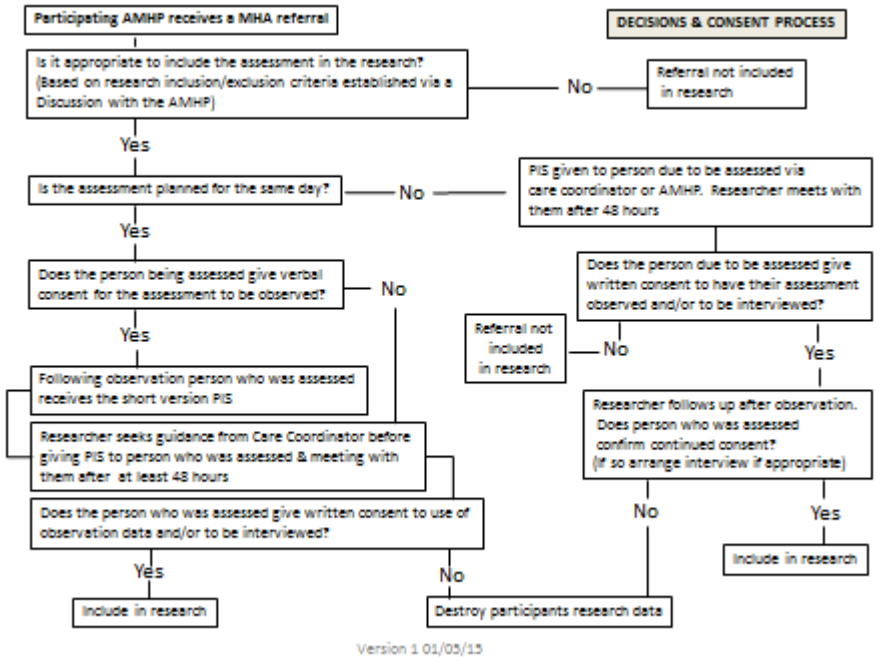
Provisions were made that any AMHP or service user participants would be given the opportunity to withdraw consent at any time during the observations. AMHP's within the teams who did not wish their practice to be observed were reminded that they were free to refuse to consent and I agreed to ensure that any observation be suspended should that worker have any interactions with the participating AMHP.

As part of the application for ethical approval I considered the potential that for service users, being observed and talking about their experiences of being assessed and potentially

detained under the MHA could be emotionally distressing. Stress is thought to contribute to relapse of mental health issues (Zubin & Spring, 1977) and so this needed to be addressed as a risk. These risks were balanced with the benefit to the service user participants as research suggests that having a voice and being heard is empowering to individuals and that this leads to a positive outcome of mental well-being (Postle et al 2008).

Prior to an observation of practice, the person being assessed would be asked to give verbal consent for me to be present. As there was the possibility that an additional person being present at the assessment could cause further distress I assessed and managed this on an ongoing basis throughout the observations, with a low threshold of stopping the observation if necessary to prevent further distress.

Figure 1: Decisions and Consent Process as agreed by the Social Care Ethics Committee



3.12 Researcher Safety

It was necessary to consider my own safety during the fieldwork particularly as I was in the late stages of pregnancy when carrying out the observations. During the observations I was in the company of the participating AMHP. An assessment of potential risk to participant and researcher safety was carried out through a conversation with the AMHP prior to each assessment. I also drew upon my practice experience of carrying out Mental Health Act assessments and my wider Social Work practice to assess and manage any risks to personal safety and would have withdrawn from a situation where this could not be maintained. If the AMHP advised that the observation should stop due to risk to participant or researcher safety I confirmed that this would be respected.

I also agreed to adhere to Local Lone Working Policies outlined how I would ensure that the individuals care coordinator was aware of any visits to carry out interviews, and also that the team base is informed when the interview has finished and I was leaving the research site.

3.12 Accessibility

Prior to commencing the fieldwork, it was necessary to gain favourable ethical approval from the Social Care Research Ethics Committee. Alongside this I was required to fulfil the requirements of the NHS Research and Development procedures which required amongst other things an Occupational Health Check, Hepatitis B jab, research passport and DBS check. I also had to have all the interview schedules and participant information sheets and consent forms reviewed and approved by the local Service User Network group prior to starting the fieldwork. Given the relationships I had nurtured from the start of the project I was able to start recruiting participants as soon as I received a favourable opinion. However, as is outlined later in the chapter when I set out the aims of the research and compare these to what actually happened, gaining access, and recruiting AMHPs was relatively straightforward. Issues arose when navigating what activities, I could report on once out 'in the field'.

3.13 Anonymity and Data Protection

As the research is a qualitative enquiry direct quotes will be used in the research findings. However, these have been anonymised and local identifiers removed. Participants were made aware of how the findings would be presented via the participant information sheets. A digital recording device was used to audio record observations. This device was password protected and the file uploaded to a University of Leeds computer with a password protected

file that only I had access to, as soon as possible after the recording has been made to ensure it was securely stored. The files were named using the participant ID to ensure that no personal information was saved or associated with the audio recordings. During the fieldwork I made hand-written notes in a notebook and used ID numbers and pseudonyms for participants to ensure that no identifying personal data was stored with these notes. After each observation I typed up field notes and saved as password protected files. Once typed up the paper notes were securely destroyed.

A list that links the participants with their ID numbers and their pseudonyms were stored as a separate file on a University of Leeds computer only accessible to the researcher. All electronic files were automatically backed up daily - to the secure University of Leeds server.

Signed consent forms were stored in a locked filing cabinet at the University of Leeds, School of Healthcare. This is in a keypad accessible office that only PhD students within the School of Healthcare can enter. Field notes were stored in this locked filing cabinet in the key accessible PhD office at the University of Leeds, School of Healthcare. All electronic data was stored as files on a password protected University of Leeds computer, only accessible to the researcher.

3.14 Confidentiality and Disclosure

All participants were made aware that the Researcher was a registrant of the Health and Care Professions Council and thus bound by their standards of proficiency which includes to 'be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users and carers or others (HCPC, 2012, 7.2). It was also necessary for me to refer to the local Whistleblowing Policy within the case study site to ensure local procedure could be followed in the event of a disclosure.

If an AMHP or service user participant were to disclose information that seemed to raise a safeguarding issue in relation to Safeguarding Vulnerable Adults policies (DofH, 2000b), the Safeguarding Lead and/or AMHP Line Manager would be informed. For example, if a practitioner disclosed information that indicated they had caused another person intentional harm or deliberately acted illegally.

The participant information sheets for all participants clearly stated what actions would be taken in the event of a safeguarding concern being raised. For example, if a service user participant was to share information that seemed to indicate that they or someone else was

in immediate danger, that individual's care coordinator would be informed, and the information passed on. I planned to manage some of these risks to the research by reminding participants of the waiver to confidentiality during the interview if it seemed a disclosure may be made.

Any findings that used direct quotes from the interview transcripts were carefully checked to reduce the risk of identifying data being included in the final thesis. For example, specifics related to circumstances surrounding admission were not included in any reporting of the research if it seemed that the individual could be identified by others than knew them well. This was particularly pertinent if a service user disclosed their negative views about a practitioner or service and may then be concerned about this third party being able to recognise themselves as the focus of discussion. This is one drawback of using a case study approach where participants are likely to know each other even if they do not share that they have participated in the research.

3.15 Complaints and Concerns

All participants had my contact details to report any complaints or concerns and in recognition that they may prefer to talk with someone else about these, the participant information sheets also had contact details of both of my academic supervisors.

3.16 Incentives

Further to taking advice from a service user consultation group, a £20 high street voucher would be given to service user participants in recognition of the time and knowledge that they have shared. Offering small financial incentives is advocated by Faulkner (2004) who provides guidance on the ethics of carrying out survivor/service user research.

All participants received a thank you card for their participation to reinforce the value that is placed upon their contribution to the study.

3.17 Risks and Benefits

Both AMHP and service user participants were reminded that if they disclosed any information that indicated malpractice in the case of the AMHP, or a risk to their own or others safety in the case of the service user, that this information would be shared with the AMHP's line manager and the service user's care coordinator. The principles of Safeguarding Vulnerable Adults were used to inform these decisions to disclose. I drew upon my previous

practice experience of operating within this framework. As a member of the Health and Care Professions Council (at the time of the fieldworks) I had an awareness of my professional duty to share information that indicated that a worker may have acted illegally or in a way that is abusive or neglectful to service users. The Health and Care Professions Council required that they required of registrants that all actions undertaken would remain in line with the bodies standards of proficiency that included an expectation to practice 'within the legal and ethical boundaries of their profession' (HCPC, 2012). This requirement rested heavily, and I spent much time invested in grappling with the ethical dilemmas associated with the research design.

As a Mental Health Social Worker and AMHP, at the onset of the fieldwork I had over ten years' experience of working with individuals with severe and enduring mental health needs and of assessing people under the Mental Health Act and Mental Capacity Act (2005). The interviews with service users would be terminated and the data not used if there were any concerns on the day that the participant was unable to give informed consent to participate. This would be assessed using the principles of the Mental Capacity Act 2005 and based on asking the participant to clarify their understanding of the content of the participation information sheet, the purpose of the study and also situations where confidentiality may be seen as needing to be breached.

Observations of social work practice 'in the field' is also advocated by Ferguson (2014) who notes that little research focus has been given to what actually occurs in social work practice between practitioners and clients, with the majority of ethnographic studies taking place within the office environment rather than in the community, within service user's homes. The benefit to the AMHP participants is that they are contributing to a further understanding of the demands of the role. There is a risk that being a participant places a burden upon the AMHP as they would be subject to extended periods of having their work observed which could be tiring or perceived as intrusive. This would be managed in part by taking guidance from Hammersley & Atkins (2007) on managing field relation in terms of establishing working relationships and reflecting constantly on behaving in an appropriate manner, backing off and giving the AMHP space as needed and respecting the time that the AMHP is giving to be part of the study.

3.18 Validity/reliability/triangulation

Pawson et al (2003) suggest a framework for considering the strengths of social care research in terms of the types of knowledge that are drawn upon to inform the research:

- Organisational knowledge
- Practitioner knowledge
- the policy community, that is, knowledge gained from the wider policy context
- research, gathered systematically with a planned design
- service users and carers. (pviii)

Whilst this framework was developed for the purposes of carrying out quality systematic reviews, the principles still have relevance to wider social care research. In terms of the data collected for the purposes of the research practitioner, researcher and service user knowledge were gathered which then enabled an analysis of different standpoints on the research questions.

In terms of methods, the purpose of using observational methods alongside interviews was to generate data that considered AMHP decision making in vivo and on reflection in terms of how AMHPs talk about what they do. Froggett (2012) describes this combination of methods as:

> *'Practice near 'ethnographic observation using free-floating attention and thick description and practice distant methods 'semi structured interviews'* (Froggett, 2012).

The Case Study design, whilst situated within a particular context in terms of socio economic and demographic factors (for example an urban inner city setting), does provide the opportunity to frame the data generated within a clear research site in terms of team culture, and the resources available to the AMHP participants. When considering decision making this has relevance as the findings relate to AMHPs working within the same context. For example, had the participants been situated in teams across England, the contexts within which they worked may have varied. Given the small number of participants involved in the research potentially this could have led to the themes identified within the data becoming less reliable as a means of shedding light on AMHP practice. The Discussion chapter explores this in more

depth when then considering how context specific research can have relevance to wider AMHP practice.

Pawson et al (2003) have developed a set of questions to critically evaluate the quality of any type of knowledge. For the purposes of this thesis I have put the questions to the research knowledge generated:

- Transparency – is it open to scrutiny?
- Accuracy – is it well grounded?
- Purposivity – is it fit for purpose?
- Utility – is it fit for use?
- Propriety – is it legal and ethical?
- Accessibility – is it intelligible?
- Specificity – does it meet source-specific standards? (2003, pv)

Throughout the research I aimed to fulfil these criteria with transparency throughout in terms of researcher standpoint, epistemological positioning around the research topic, and respect towards the ethical review process, including the ongoing reference to negotiating consent.

Tew et al (2006) identify how 'insider' knowledge, -in this context data from the AMHPs and key informant, plus my own perspective as a Practitioner Researcher - should be combined with a clearly defined approach to analysis in order to produce good quality research:

> *Good research needs to combine the 'insider' (experientially based) knowledge and insights of service users and carers with frameworks that give space for rigorous analysis, so that a clear and authoritative picture can emerge (Tew et al,2006, p7).*

As I outline later in this chapter when discussing the approach to analysis, an acknowledgement of the impact of the analysis on the transparency and quality of the research was paramount during the analysis.

3.19 Data Collection

Through use of two data collection methods, their choice informed by research theory, I sought to ensure triangulation of methods. The observations, interviews, transcripts and

fieldnotes enabling an approach to answering the research questions that was based on a broad range of perspectives to the questions. For example, the fieldwork sought to capture practice 'in the moment' or 'in vivo' and the practitioners' reflections on their practice in the interviews elicited data around how AMHPS talk about what they do. A key element of the research design was to ensure that a source of knowledge on the research question was a sought from those whose lives were impacted upon by the AMHPs decision making – the person being assessed.

3.20 Recruitment - What actually happened:

The chapter thus far outlines my original intentions, research design and the intricacies of the ethics applications which involved dealing with a range of possible situations that could arise during the observations. On paper the research had grand aims. The reality when I came to the point of the data collection led to quite a different picture and required ongoing reflexivity, patience, and some level of determination to develop a rich data set from which to identify meaningful findings. This was primarily due to issues around recruitment, access and adhering to the inclusion criteria as determined by the ethical approval.

Initially five AMHPs volunteered to participate in the research, three of whom who were based together. As outlined below, an additional four AMHPs were recruited in a second round of recruitment.

The following table outlines the demographics of the participants and range of years post qualifying as an AMHP:

Table 1: AMHP Participant Demographics

AMHP Participant Demographics	
Gender:	5 Female 4 Male
Years post qualifying: Given the small number of participants and risk of providing identifying data, years post qualifying have	Under 5 years: 4 5-10 years: 2 15-20 years: 2

been provided rather than the age range of the AMHP.	
Ethnicity:	All participants were white British

It is of significance that the participants were of the same ethnicity. As will be explored within the Discussion chapter, this lack of diversity within the participants does limit the findings of the research as it was not possible to include the experiences of AMHPs from black and minority ethnic groups for example. National statistics regarding AMHP demographics were not gathered centrally at the time the research was designed, but in 2019, 2 years after the fieldwork was completed, Skills for Care provide a summary of AMHP demographic characteristics based upon data gathered from the National Minimum Data Set for Social Care:

> *'Overall, AMHPs are more likely to be male, older and white than the social work workforce. Data from the NMDS-SC shows that while 21% of social workers are aged 55 or over, this rises to 30% (almost in 1 in 3) when we look at just AMHPs. With regard to gender, overall, 19% of social workers are male, this rises to 29% when only considering AMHPs. Lastly, 77% of all social workers are white, this rises to 85% for AMHPs.'* (Skills for Care, 2019).

Given that the majority of AMHPs are white British the participants ethnicity reflects this trend.

The next table outlines the data that was generated during the fieldwork, and a summary of the barriers encountered. This information was collated within a Reflective Diary. Key to enabling me to navigate the challenges that arose during the whole research journey was my use of a Reflective diary, which I wrote from the early days of the PhD journey. This document was a place in which I could untangle thoughts related to methods, ethics, research design and how the data gathered would be able to answer the research questions. The diary also served as a tool to develop ideas and to then use supervision as a forum to discuss and hone

these, particularly in relation to the limited access I had to participants and also to opportunities to observe Mental Health Act assessments.

This part of the research journey required reflexivity to respond to the challenges encountered when gathering data in terms of how to maximise the data that could be used within the project, but also how to optimise then richness of what was being gathered. This included shifting my focus from frustration at what I was unable to observe, to valuing the data that I was able to collect.

Table 2: Fieldwork data collection summary:

Data Collection Summary	
Total Fieldwork Hours: 60 over 5 months AMHP Interviews: 8 Key Informant Interview:	4 with AMHPS who were observed, 1 with an AMHP who an observation participant was but no suitable assessments arose, 3 with AMHPS who were not observed and recruited later due to limited data. **1**
Observations of AMHP in office • PA – 5 hours spent observing arrangements being made for assessment that it was not appropriate to attend due to issues around capacity to give informed	**Observation of assessment** • PB carrying out assessment at 136 suite • PA attempting to carry out assessment in the community (person didn't answer the door)

consent (SU has advanced dementia). • PB – 3 hours spent observing assessment at 136 suite. • PA – 7 hours observing arrangements prior to a community assessment (warrant needed). • PC – 2 hours observing arrangements for a community assessment but as there was no bed this did not go ahead. • PC – 6 hours observing arrangements for carrying out assessment in a care home • PC dealing with an assessment where there was no bed identified. • PA organising ward assessment (that I observed) • PE dealing with an assessment for an older person with dementia. • PA organising police custody assessment (that I observed) • PC dealing with assessment for which there was no bed.	• PC carrying out assessment at a care home • PA carrying out assessment on ward (S3) • PA carrying out assessment in police custody (S3)
AMHP Interview Interview with PB re the 136 assessment Interview with PA re ward assessment	**Interview with person who was assessed** **None recruited**

Interviews pending PC re the care home assessment.	
Barriers to data collection	
Referrals it was not possible to attend:	• Referral for participant with a learning disability (3 hours fieldwork unusable). • Plus, t/c from PB re two assessments it was not possible to attend (a child and person with severe learning disability). • Non-English speaker & issues around gaining informed consent. • Referral received for service user with severe dementia • Referral received for service user with severe dementia • Referral received but risk of violence to others perceived as high (police Taser team involved – not appropriate for me to attend).
Other barriers to data collection:	• On three duty days no referrals were received by the participating AMHP (plus another 3 days where I was on

	standby – not included in the total fieldwork hours).
Barriers to recruiting people who were assessed under the MHA	• One consented to use of the observational data but declined to be interviewed • One deceased and daughter gave consent posthumously • One asked for all data around assessment to be destroyed • One remained too unwell to give consent to use of data or to participate in an interview

Using a Reflective Journal enabled space to recognise the impact of carrying out fieldwork as a distinct part of the research journey. I did experience a sense of frustration that after the year long process of gaining ethical approval the challenges were not over, even once I was over the threshold of the participating AMHPs office door, sat eagerly waiting with notepad in hand. This is the point at which the challenges began in terms of making decisions along with the AMHP as to which referrals it would be appropriate for me to attend. I spent many days sitting in the office waiting for something to happen or having to leave early as the inclusion criteria was not met when a referral did come in.

Another barrier was that due to maternity leave I had a finite period of time within which to gain informed consent from the people who had been assessed to use the observation data that was specific to an assessment, for example around risk issues and specifics of the case, and also to gain consent to participate in an interview. Even within a five-month timeframe two of the people whose assessments I had observed remained too unwell, in the opinion of their care coordinator, to approach to discuss participation. I also attempted to follow up consent on my return from leave but unfortunately two of the people who had been assessed were no longer in contact with mental health services.

I have reflected on the time and effort that went into gaining ethical approval but maintain that the original aims of the research were justified and that perhaps if a bigger study were to take place with researchers involved who are themselves people with lived experience, some of the barriers might have been broken down and participation may have been higher.

3.21 Rationale for broadening the inclusion criteria:

After discussion with my Supervisors the decision was taken to undertake a second attempt to recruit AMHPs specifically to participate in the interviews. The fieldwork observations and reflective memos plus the initial interviews had provided rich data around decision making but there was scope to gain further knowledge around decisions making given I had been unable to recruit the ten AMHP participants as I had originally aimed to do. Due to time constraints it was not possible to carry out further observations of their practice.

I took the decision to include a Key Informant Interview – the viewpoint of an individual who had previously been assessed under the MHA but not during the observations, as insights and knowledge from this perspective had been an integral part of the original research design. Therefore, whilst the interview was not able to shed light on decision making on a specific assessment – exploring the viewpoint of the AMHP and the person who had been assessed, the data generated still contributes to an understanding of the AMHPs role in decision making. The Key Informant was recruited via Service User network links – the individual approached me to ask to be involved within the remit of the work they carried out to promote awareness of mental health issues within professional training, identifying as an 'expert by experience'. She was a white female in her 30's.

I did consider if the interview data from those AMHPs whom I observed should be privileged over the interview data from those who were not observed as the interviews focussed on an assessment of the AMHPS choosing. Whilst I aimed to reduce the risk of the AMHP opting to discuss a particularly challenging or risky case by asking them to talk me through their most recent assessment, during some of the interviews the AMHP steered me to assessments that they felt had more to say about decision making. With such a small sample I took the view that it would not be empirically sound to make comparisons between the two types of interviews in terms of the research findings and for transparency note that there may have been an impact on the depth and richness of data where a relationship had not been

established prior to the interview. This may be a limitation of the research in terms of a dilution of the original research design and methods, but for the scope of a PhD research project on balance made the decision to include all interview data as one data set.

The next part of the chapter outlines the Pilot for the project and how I responded reflexively to the evolving context of the research. This led to the need to develop a particular set of research skills including flexibility, reflection, and pragmatism. In terms of contributing insight into research methodology around practitioner researcher the research journey sheds light on the messy reality of carrying out research versus what is planned carefully on a page.

3.22 Pilot Study - reflections

To inform the ongoing approach to research – and to respond reflexively to the ethical challenges inherent when using observational methods, I took a reflective approach when piloting the observations and interviews. Due to the difficulties in gaining access to the research site, and the time setting up the observations to align with the participating AMHPS duty days, I was pragmatic in my approach to the pilot. There was a significant risk to the research project if I built in further delay to the timeline of fieldwork, and so the initial observations days and interviews were used as opportunity to pause and reflect on the approach I took.

The following section outlines this, based upon notes made in my Reflective Diary, also demonstrating that this stage of the research led to early analysis of the data:

Observations in the office:

What went well were the ways in which I negotiated settling into the office space. For example, I took time to think about where I sat in the office, conscious to ensure that I was not sat in anyone else's seat, and also close enough to the AMHP to observe their day, without being too intrusive.

Some unexpected situations arose, that cannot be anticipated in advance and dealt with on an ethics application form. For example, during one observation the participating AMHP passed me their mobile phone to answer as the AMHP was busy on another call. In this instance I took a message and didn't get involved in any discussions, but recall needing to

'think on my feet' and experience the dilemma of wanting to be of help but conscious of my 'observer' role. In terms of maintaining relationships this was the best course of action, but the event reinforced the evolving nature of observational fieldwork in terms of research methods, design and navigating consent. It also highlighted how as an observer of practice it was not possible to be 'neutral' such as if I was watching what occurred from behind a mirror, or in retrospect on a video screen. I was very much part of the dynamic of the room and it was necessary to acknowledge and reflect on the ways in which my presence as 'participant observer', impacted on what occurred and how I recorded this. Given that the AMHP participants worked in fairly quiet office spaces and we were often one to one during the duty day, I reflected upon how it felt harder to be an observer, for example when getting a running commentary as to what the AMHP planned to do next. I found that the AMHP's seemed to use me as a sounding board, speaking aloud to posit questions. Clearly, I was not there to make any decisions on the case but still had to navigate striking the balance between being interested but also maintaining an observer role.

Another incident occurred when I dealt with the team manager chatting to me when I was attempting to note down a telephone conversation the participating AMHP was having. Not wanting to appear rude I entered into conversation, possibly at the expense of missing a key part of what the AMHP was doing. This was driven by my need and want to take the time to 'fit in' and to reciprocate the generosity of the participants in giving their time to the study, yet also maintained the role of researcher. During later observations as I became more comfortable in my researcher role I took a firmer stance and became more comfortable in my relationships with the participants to talk about how I felt about not being able to help (e.g. when one of them asked 'what would I do…'). This enabled me to nurture open and honest communication between us which arguably benefitted the interview stage of the research as a rapport had been formed to potentially elicit the AMHPs open reflections on their practice.

In terms of making fieldnotes, after the initial observations I reflected on what had become the focus of the notes, questioning what I consciously left out or decided to leave in. I was unsure how the AMHPs would articulate their decision-making processes, or how I would make sense of this. I had in mind an awareness of the nature of tacit knowledge 'the

importance of what practitioners do not consciously know or cannot express although they use it in their daily practice' (Schon in Frogget, 2012, p5). I took steps to overcome this anxiety by writing everything down verbatim, grateful for being able to handwrite speedily. The first transcriptions reminded me to attend to this soon after the observations to ensure I could read my own sometimes hard to decipher scrawl. These verbatim notes became even more valuable as the fieldwork developed and it became apparent that the majority of the data would be accessed via time spent in the office with the AMHPs, given the difficulties with access and ethical approval when observing the interview stage of the assessment.

What didn't go so well during the early days of the fieldwork was primarily linked to my shift from practitioner to researcher. I reflected that I tended to become too involved in anecdotes – realising that I was missing being part of a team and being in a social work office, for example the camaraderie. However, by being open and sharing something of myself perhaps this paved the way for more open discussion and the AMHP to trust me, for example, forming a rapport.

An example of this is evidenced in a reflective memo:

> *Note from reflective memo log: 'PA is a good orator, explaining his rationale and not shielding me, i.e. not always by the book, open about his personal life, explaining why he doesn't use some doctors'.*

As a result of these early pilot reflections on being within the office space, I made some amendments to how I carried out the fieldwork moving forward. Having reflected on the dynamics between myself and the participating AMHPs, particularly when in a one to one situation, I made an effort to overcome the risk of the observation steering towards conversation of our practice experiences and adopted a more enquiring approach. For example, I used open questions and Socratic dialogue - the 'Columbo' approach – not just having 'a chat' but ensuring that there was a purpose to my enquiries. This would include encouraging the AMHP to explain themselves, describe what they were doing in more depth without making assumptions that I knew why they were doing something. This did feel uncomfortable at times as I felt that the AMHP did not have the time to clarify what I think I know the answer to ('Why is she asking that, doesn't she know??'), but from a research

perspective this was the data to capture as it could challenge my assumptions and expectations, given my knowledge of the AMHP role.

The early days of the fieldwork also led to unexpected learning opportunities. Situations arose where a referral did not amount to an assessment due to factors such as a lack of a bed or the individual not opening the door to be assessed. Whilst I was unable to gather data regarding the decision to detain or not, the data I did gather shed light on the various other decisions that the AMHP made when managing the referral. A very interesting area of decision-making was highlighted around how the AMHP manages situations where there is concern regarding risk but no way of doing anything, for example as there is no bed that the individual could be admitted to if necessary.

Observation of assessment:

Reflecting on what went well after the first observation of the AMHPs face to face interview I considered the ways in which I conducted myself during the event. I took the time to introduce myself and explain what I was doing there at the assessment. The AMHP assisted with this conversation and we placed the emphasis on what the AMHP was saying and doing being the focus of the research at that stage.

I reflected on the value of the data that was gathered, for example during the first assessment I noted that the busy hectic environment provided research data to illuminate the context within which decision making occurs:

> *'PB: In terms of decision making, its quick decisions today'*
>
> *'The design of this place is not good, it's like a goldfish bowl' (PB commenting on the environment at the 136 suite with another service user leaning against the window staring in at us). 'It's not safe'*
>
> *PB: 'I don't know whether I'm coming or going'*

I noted in the reflective memo that the AMHP had not appeared perturbed and had come across as calm and measured, not flustered at all. I compared this presentation with myself considering how if I would have coped if I was there in my AMHP role. This reflected led me

to recognise the potential that I used myself as a benchmark when observing AMHP practice, considering if this was inevitable and if so, how I would recognise this and the potential impact on the analysis of the data. This led to ongoing reflections around looking for difference from the ways in which I would have approached a referral.

The first observation also led to reflections about the logistics of the observation, for example, where I sat. During the interview I ensured that I was not within direct line of sight, but next to the person being assessed, to reduce the impact of my observatory role as much as possible.

I had anticipated difficulties in gaining consent from AMHP co-workers, evidenced in the complex and long considered Participant Information sheets for this cohort. In practice they were happy and quick to give verbal consent. This was interesting and I felt surprised that they did not ask many questions regarding the research but were supportive. Being an 'insider' seemed to help. The AMHP introduced me as '*This is Charlotte, she's an AMHP but she's doing some research on me*'. I did note in the reflective diary that at times I felt concern that gaining access was too easy and worry that perhaps I was not transparent enough about my role.

There were things that did not go so well during the assessment, which I recognised. For example, audio recording the observation was not possible as the two assessing doctors and AMHP were not supportive of this, plus I did not think it was appropriate. The Ethics Committee granted approval to record the observations subject to gathering informed consent, but I did not feel comfortable asking for this during any of the further assessments as it felt an unnecessary intrusion. However, due to the slow pace of the assessment it was possible to make verbatim notes on what the AMHP was saying.

I made significant reflective notes about how I collected the data, and the trials and tribulations of what paper to use. I was conscious, for example, of turning the pages on my note pad. I had purposely taken a smaller pad in to write notes as I thought this would be less intrusive, but it transpired that it was more distracting as I had to keep turning the pages,

which was quite loud. I also forgot to write down timings, not writing down how the AMHP informed the person of the section.

The initial observation also led to reflections on personal safety. Whilst I ensured that I did not take up a position of 'power' in the room (on a higher chair, directly opposite the person etc) I did the opposite of what I would do from a practitioner risk assessment point of view i.e. I was furthest from the door and the closest to the person which potentially would have put me at risk had the person become distressed or agitated.

Further to these reflections I amended the ways in which I approached the rest of the fieldwork:

- Explaining why I was taking notes and what I was writing (what the AMHP says).
- Using a larger and quieter note pad for fieldwork observations.
- Consulting with the AMHP prior to the assessment about where I should sit.

Informed Consent process:

Gaining Informed consent was an area that I felt quite anxious about prior to starting the fieldwork, linked to the amount of time I had spent compiling the detailed application for ethical approval. Despite these anxieties, I reflected on what went well further to the first observation. I experienced significant help and enthusiasm from the participating AMHP to follow up with the person who was assessed. This was perhaps made easier as she was regularly visiting the wards to see other people. She went to see him on the ward a few days after the assessment to hand over the short information letter but felt that she risked deterring him from considering participating as he still seemed very afraid and troubled by his beliefs and not able to attend to what she was trying to tell him. The following week she sent me an email:

> *Email from AMHP Participant B: 'I went up to X's ward again last week with your letter, but staff advised me he was still really unwell and quite paranoid (he can only be given a low dose of meds due to sensitivity). I saw him & he didn't look at all "with it" (I don't*

think he recognised me). Therefore, I thought it wise to retreat and try again later, as paranoia may make him more likely to say no to you'.

I agreed a plan for her to continue to follow up as his mental health improves and fedback my appreciation that she had taken such proactive steps to increase the likelihood of the person receiving the information they would need to make a decision regarding informed consent to participate in the research.

Some aspects of the observation went less well. For example, I had not factored in that if the time frame for gaining informed consent went over 4 weeks the service user may have been assessed for a second time under the MHA (e.g. if detained on a section 2 and then assessed for S3). However, as the first assessment is likely to be the one that brought them into hospital I remained hopeful that as this is potentially a key experience for someone they would still be able to recollect and reflect on this for any interview purposes. I considered that it may be that the individual had little recollection of the event which would be interesting and important to capture given the implications for participatory decision making.

Further to these reflections I made amendments, related to the way in which I perceived timeframes as it seemed that a four-week period to gain informed consent was optimistic and I may well have to be prepared to follow up for a period longer than this dependent upon each individual's circumstances.

Interview with AMHP

In terms of what went well during the first interview, the AMHP was forward coming in engaging with the interview process – it lasted for 1 ½ hours. I ensured I provided the opportunity to stop the interview around the hour mark but the AMHP indicated they were happy to continue talking. This gave time to cover questions relating to the context of their practice and the specifics of the assessment that was observed.

What went less well was issues linked to time management and logistics given the realities of the unpredictable nature of the AMHP role. Due to the AMHPs workloads and commitments it was necessary to reschedule the first interview, which was time consuming as I had arrived at the team base and it the interview was cancelled at the last minute. The first interview had to be postponed as by the time I arrived the AMHP had received a referral and so needed to

prioritise this. This took up half a day (driving to their office and back plus time to reorganise the interview). The AMHP was helpful and rescheduled for the next day but this was a reminder that even with the best laid plan's fieldwork is a somewhat messy and disjointed experience.

The cancellation also led me to reflect upon the emotional state of the AMHP during the interview. I characterised this as 'having the 'headspace' to do the interview' in the reflective diary. I also noted the impact of time and the timing of the interview further to the observation. For example, the AMHP had done other assessments in the week since the observation and noted that it may not be possible to recall all the details. My reflections and verbatim notes helped here as I was able to frame my questions in relation to the assessment which the AMHP fedback helped trigger memories.

In response to this reflection I made some amendments in the approach to planning the follow up interview with the participating AMHPs to set the scene as effectively as possible for *t*he AMHP to have the time and reflective space to do the interview, and planning for managing this. One strategy was to aim to arrange them early on during the persons duty day, whilst their day is clear, although this then then risked interrupting the interview if they receive a referral. Mindful of the timing of the assessment and when to carry it out I also made time at the close of further interviews to seek feedback about the experience of being interviewed.

Dealing with the unexpected:

Early in the fieldwork the dissonance between the research design in terms of the plan I had gained ethical approval for on paper, and the reality of navigating consent when carrying out real time observations of practice, became apparent. All the participating AMHPs made remarks that I began to categorise as 'off the record'. Two different dynamics emerged during the observations at the pilot stage – one to one observations and observing two AMHPs in the office together. An unsaid code arose whereby when I didn't have my note pad out, they

would know I was not recording verbatim (e.g. when I lent my pen and we joked that this would stop me writing). This might occur when the topic of conversation was unrelated to AMHP practice, or during tea breaks for example. It was also necessary to manage sensitively negative comments regarding management. One AMHP spoke of how home life had impacted on practice with one particular assessment when we were talking informally in the car and I was not taking notes. I managed this by using reflective memos to note these 'pearls' and to use the reflective interview to give space for the AMHP to return to this conversation during an 'on the record' conversation where consent to the use of data was transparent. In terms of negotiating ongoing informed consent, I reflected upon how out of around 80 potential AMHP participants, only 6 had agreed to participate in the observational stage of the research and reassured myself that they must have thought about the implications of being a participant (assuming that this was a factor in deterring the other 73 from participating).

The early days of fieldwork also highlighted the issue of how to deal with uncompleted assessments. For example, where one AMHP was unable to carry out an assessment as there were not beds locally or nationwide and due to risk issues could not begin the assessment. This led to a realisation that the research focus may shift upon some of the other decisions that AMHPs make - if there was no bed to potentially admit to, how do they deal with this? I also realised that as the local practice was to 'pass on' the referral and this had always gone to a non-participating AMHP, I would be unable to see 'what happens next' with the referral. This shed light on the non-linear nature of AMHP practice and that my plan to collect data that neatly moved through the stages of an assessment from referral to potential detention, were unrealistic in practice. I would need to deal with the data in a more fluid way to answer the research questions.

A final area that I was required to navigate was how I responded when I was asked for my opinion. For example, when one AMHP was '*agonising*' (their use of word) over a letter intended to inform the person due to be assessed that they would be seeking a warrant, I was asked for my opinion on this:

PA 'I know you're not supposed to tell me…..'

I managed this by giving some feedback on what the AMHP had said and something validatory along the lines of the AMHP was clearly taking time to think through what to do next in what I agreed was a very challenging situation. Another moment occurred when I asked a question during the observation that led the AMHP to say 'I feel stupid now' as the question prompted them to recall that the address on a medical recommendation may be incorrect. This statement was made 'in jest' but to make sure I then shared an anecdote from a time when I had made a mistake on a section paper, to demonstrate my own fallibility.

The biggest challenge that the pilot/early days of the fieldwork elicited were the timescales involved and the 'messiness' of data collection. The fieldwork was time consuming in terms of waiting for referrals to be received that were then also appropriate to observe in terms of the eligibility criteria, plus discussing the appropriateness of observing which I felt was an additional demand on the time of the already pressurised participating AMHPs. Whilst they were all supportive and accommodating, I remained mindful of this burden throughout the course of the fieldwork.

3.23 The Impact of being a 'practitioner researcher'

To inform the reading of the analysis and the lens through which I considered the data, it is necessary to set the scene in terms of my role as a practitioner researcher and the ways in which relationships were established and developed with the participating AMHPs. As the observations from the pilot suggest, this has a bearing on the analysis as the reflective memos formed the initial analysis, reflecting 'in action' on what I was observing. As much time was spent one to one with the AMHP some of the verbatim comments gathered during the observations were comments made directly to me, thus becoming a form of interview data. How I captured these and began to make sense of the comments impacted on the interview questions and themes generated in the more formal interview setting. I was aware of occupying a space as 'participant observer' given my role as AMHP and the dynamics between myself and the participants during the fieldwork and the standpoint from which I undertook the research (Hammersley, 2000).

3.24 A reflection on the observational methods

Prior to commencing the fieldwork, I had spent two afternoons in the team base where three of the AMHPs were based to provide participant information and complete the consent forms.

It is common practice to have a social work student within a team and initially I was viewed as a 'student' on placement, enabling me to fit into the workspace relatively quickly, and perhaps viewed as 'non-threatening' - my research of interest but not apparently viewed as an 'inspection' or audit of the workplace. I brought in milk and teabags, recognising from my own work experience that the seemingly small details of working life can become the issues that lead to tensions and frustration between staff members. I also took in cakes and biscuits and generally tried to ingratiate myself in the team setting. There was a lot of sitting about waiting for something to happen and it was always necessary to have an awareness of how to fit into the office setting to avoid the AMHP feeling scrutinised:

> **Extract from reflective memo:** ***I keep forgetting a book to read (so I can occupy myself whilst 'nothing' is happening). BUT taking time to get to know the participant***

As an AMHP, social worker and as a pregnant woman I soon found shared ground that enabled me to develop a rapport and to feel more comfortable in a role that at first felt difficult. I was aware that it was a busy office and that they were doing me a 'favour' allowing me to observe what went on behind these closed doors. As the weeks went on there were times that I questioned my role and purpose:

> ***Extract from reflective memos: I get the impression I'm becoming a burden – why??? Last time wasn't expecting me, no reply to email or text..however, is probably just the case they are too busy. How to navigate this? Have emailed to confirm [the next date] when I will go in-but feel need to be more tenacious? Strategy – go in on the [next date] anyway? Ask about being a burden and recheck consent?***

Consent from the participants was a constantly evolving concept as time passed and they continued to invite me to observe their duty days. I was also aware that this was my main opportunity to gather data and with the birth of my child looming I soon overcame the concern that I was 'burden'. My primary aim was to utilise all opportunities as every day that I spent observing elicited the richness of data that I had hoped the research design would evoke. I never overcame the sense that I was an 'outsider' trying to be an 'insider', but this tension provided me with the distance I needed to prioritise my role as a researcher rather than a practitioner. The six-month duration of the fieldwork did lead to relationships being

developed which I suggest are evident in the data generated from the interviews with the AMHPs, and the unguarded comments made during the assessments.

Questions that arose during the fieldwork, prior to the analysis of the data included:

- How does my position as a practitioner researcher impact on the dynamics between me as interviewer and interviewee in terms of the data that is elicited?
- Should I privilege any one type of knowledge, for example that which is gathered from a service user perspective? It can be argued that as a disempowered group one responsibility of the researcher is to give 'voice' to these individuals? Guidance from Pawson et al (2003) is a helpful framework for addressing these issues.
    - How do I narrow the research focus during the fieldwork – i.e. what did I write down, take note of during the observations – how do I reflect on what I had observed and use the interviews to reflect on this with the AMHP participant.

This summary of reflections on the pilot study outlines how the research design evolved in response to the challenges and dilemmas that arose early in the fieldwork.

3.25 Practitioner Researcher challenges

As has already been referred to, a key challenge for me as a Practitioner Researcher was managing this shifting identity and the impact it might have on the research, particularly the fieldwork and empirically investigating an area of practice with which I was so familiar. Delamont et al (2010) explore ethnography within education settings and problematise the potential for researcher immersed in a topic to see only what they expect to see whilst carrying out fieldwork. They argue for the need to make the familiar 'anthropologically strange' (Delamont et al,2010, p1). They suggest one way of doing this is to investigate another culture from that which the researcher is familiar with. The case study site for this research was purposefully in an area that was demographically and geographically very different to teams within which I had previously been based. I had always worked in rural areas and within an AMHP team structure that was organised differently to the case study site so that organisationally the structures within which the AMHPS operated had difference.

Coar & Sim (2006) explore research methodology around interviewing peers, within the context of General Practitioner (GP) practice. The interviewed GP participants about their experience of being interviewed for the purposes of research in their practice, by a peer. Amongst their findings was the potential for peer researchers to engage in a deeper level understanding of professional practice:

> '*a fellow professional can harness prior understanding of the topic and the professional culture, and may be able to pursue issues more thoroughly by virtue of not having to seek explanations of basic terminology and concepts. He or she can also enlist feelings of professional cooperation and solidarity to encourage disclosure and may gain informants' confidence more readily than a non-practitioner. It may also be possible to explore sensitive issues or tap extreme or deviant views'* (p5).

Within the interviews the power shifted, when considering power in a Foucauldian sense – Coar and Sim propose that Professional Identity can be developed and maintained through talking about what one does and thus an interview exploring professional practice can be one way that this identify is enacted. This could be considered the impact of 'performance' on observational and interview data. However, when interviewing peers, in her work around AMHP practice Gregor (2010) identified that there is the potential that AMHP's can assume a shared understanding when talking about what they do.

My experience of interviewing peers had some parallels with both these findings. One AMHP who I did not observe but who I interviewed seemed keen to impress and talk about the ways in which she challenged authority and developed her practice. Another was more defensive at times but which on reflection could have been driven by a frustration that some of my questions seemed 'obvious' in terms of an implicit understanding of what an AMHP does. "Why bother asking?"

The purpose of the research was not to answer questions around research methodology but there is scope beyond this thesis to explore this in more depth as a methodology by which to explore values-based practice. One factor that did appear relevant was the relationships that developed over time because of spending time with the participants in an office setting. Arguably this facilitated trust and openness during the interview – setting the scene to explore

themes such as values, ethics, discretion (Evans, 2019) and 'professional wisdom' (Banks, 2009).

I recognised the potential power imbalance between researcher and participants given that there was the potential for an AMHP to feel under scrutiny, whilst already in a high-pressure situation. I had also been transparent from the outset of the recruitment process that my background was as an AMHP and mental health Social Worker. This could have impacted on the AMHPs behaviour in terms of 'performance' both during the observations and during the interviews. Given I was a peer, but there was also the potential to feel that their practice was being audited. I hoped that this was mitigated by the likelihood that only those AMHPs who felt comfortable being observed in their practice would choose to participate. Social Workers are observed in their practice on a regular basis, but this is often by students on placement. In terms of the approach and manner that I took, the interview schedule was semi structured due to the nature of the qualitative enquiry, but this also encouraged the participant to lead the conversation. Prompts were included to elicit information, but the interviews were handled sensitively, drawing upon my own experiences of social work practice to engage respectfully and appropriately with all participants.

Ferguson (2014) carried out observations of child protection practice and outlined how he tried to behave in such a way as to signal difference and independence from the practitioners. He made it clear at the outset of the assessment that he was there as an observer and did not speak unless spoken to and then kept his answers short. I also took this approach to attempt to differentiate my role in that setting from my professional background i.e. clearly adopting the role of researcher rather than practitioner. I aimed to reduce any perceived threat to the practitioner who may feel their practice is under scrutiny by another social worker/AMHP.

However, during the reality of fieldwork unexpected events occurred. For example, during one observation an AMHP had omitted some information on the statutory paperwork which I noticed, and which could have made her day much more difficult to manage as this was a key piece of paperwork. In this situation I took the decision to step into the situation and point this out to her as I felt I wanted to be helpful. She told me that she felt 'stupid now'. Of course, this had not been my intention, but it highlighted for me the power dynamics

within the researcher participant relationship, and how I was perceived despite my best intentions.

I took the approach that the nature of the relationships with the participants would impact upon the fieldwork and interview data gathered. Given that I was spending large amounts of time with them and hoped to elicit honest and open accounts of their working day, establishing an open and trusting rapport was important. I was also informed by the views of Cooper around the motives for carrying out research:

> *'Research is about generating 'new knowledge' but in my view it is also about enlarging the scope of our self-knowledge in the personal, professional and societal domains. We need sound methodologies for conducting research of any kind, but actually we can only hope to generate new knowledge in so far as we are emotionally and ideologically open to the possibility of discovering something new, including things we really did not want to know. If we are blind to or defended against this possibility then the best methodologies may not help us much, although we should recognise that the formal properties of many research methodologies exist precisely in order to ensure systematic open-mindedness' (Cooper, 2009, p14).*

As previously outlined, being a practitioner researcher, I inevitably bring along an inherent bias to the research at every stage but threaded throughout the research project I reflect on this and defend and critique my position as appropriate. Maintaining a reflective diary during the research process, as advocated by Fook (2002) and Ortlipp (2008), alongside the writing of memos, ensured greater transparency in accounting for the direction that the project took and ways in which some data is prioritised and some other set aside.

Banks (2018) has developed her work around Virtue Ethics to focus specifically on the area of researcher integrity. This shifts beyond what she considers the 'shallow' area of compliance with procedures, codes and prescribed ethical standards, towards the deeper conceptualisation of what it means to be an ethically informed researcher. This explicitly places emphasis on the impact of the researcher on the research design, fieldwork and analysis and aligns with the approach that I took. I explore this further in the Discussion chapter as this is an evolving concept and Banks' work has developed alongside the timeline of this research.

One practical step to ensuring the research was conducted in an ethical way throughout all steps of the process was to include within the Participant Information sheets that any participant who so requests would be sent copies of any publications that arise from the research and also made aware of dissemination events. These actions aimed to demonstrate that the participants input is invaluable to the study, with the aim of empowering those individuals who have taken part in the research.

3.26 Analysing the data – my approach

Braun and Clarke (2022) suggest that Reflexive Thematic Analysis can align with the ontological assumptions of Critical Realism as it is an approach to analysis that 'provides access to situated, interpreted realities, not simple decontextualised truths' (p171). The approach to analysis aligned with the broader research methodology as it enabled me to identify themes that relate to the context within which AMHPs make decisions, such as legal, policy and cultural, whilst also exploring the ways in which practitioners relate to and make sense of these during their practice. For example, how policy and the law impact on practice and how practitioners interpret this day to day. This contrasts with an approach to analysis such as Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2022) that focuses on meaning making in terms of the 'double hermeneutic' – the researcher making sense of how the participant makes sense of an experience and has less focus on the context within which this experience takes place. IPA takes a particular epistemological positioning which informs any research design that then uses this methodological approach to analysis. The analysis of this research did place some focus on reflecting with the participants to make sense of their experience of decision making, and so an understanding of IPA has relevance, but the broader reflexive approach to analysis as offered by Braun and Clarke (2022) enables this meaning making in addition to allowing the space for wider contextual issues to be identified as themes.

In their original well cited article Braun & Clarke (2006) acknowledge that thematic analysis has traditionally been criticised for its lack of vigour and simplistic approach but argue that it can be a robust tool for analysis. However, they argue that when applied with transparency as to the detail of how the analysis was carried out, this approach to analysis encourages an openness on the part of the researcher to state the ways in which decisions were taken to

identify the themes rather than taking more of an objectivist stance that would view the themes as 'emerging' from the data independent of the researcher. Their model has developed over time to a model that draws upon reflexivity as the defining concept of the approach.

During the observations of practice, I wrote up and keep on top of field notes on a daily basis. This enabled me to begin the iterative process of making sense of the data, using reflective memos that Hammersley and Atkinson (2007) recommend as a tool to collect and gather any thoughts that occur during this process, whilst keeping the verbatim comments, statements from practitioners and real time observations separate to ensure the data remains distinct and avoids becoming 'foggy'.

The research design elicited two distinct data sets – the observational data which included the reflective memos and verbatim recordings, and the interview data. I used Braun and Clarke's six stage analytical framework to first code the data and then to identify themes (see Appendix). I was later informed and influenced by their most recent publication providing an in-depth exploration of Reflexive Thematic Analysis (Braun & Clarke 2022).

I transcribed the field work data and reflective memos soon after each observation day to ensure that the nuances of the day were fresh in my mind. Due to some time constraints in part due to delays in gaining ethical approval and breaks for maternity leave, I used a professional transcribing service to transcribe the interview recordings. To ensure that these were an accurate written transcript of the audio I listened back through the interviews and cross referenced against the professionally transcribed interview data to check for discrepancies and to assist in taking me back to the interview.

I used excel and handwritten notes to first code the data within and between the two different data sets to ensure that the findings could differentiate between the types of data being drawn upon. The coding led to the key themes being identified with sub themes sitting under these wider themes.

I analysed all of the data (field notes and interview transcripts) at a 'latent' level – that is an analysis that 'starts to identify or examine the underlying ideas, assumptions and

conceptualisations – and ideologies – that are theorised as shaping or confirming the semantic content of the data' (Braun & Clarke , p13).

The analysis was an iterative process, making time and space to explore the data and identify the nuances of practice around decision making. It was an intense experience, becoming immersed in the data, such was the richness of the content. One challenge was ensuring I did justice to the data as a valuable insight into AMHP practice. Again, some of the principles around researcher integrity were of relevance. Ethically I felt a sense of duty to the participants to find the points around learning and insight into AMHP decision making.

Braun & Clarke (2022) have developed a 15-point checklist for good reflexive practice, against which I have considered my own analytic journey. A key point of relevance is their claim that good reflexive analysis is characterised by '*The researcher is positioned as active in the research process; themes do not just 'emerge'* (p269). Throughout the thesis I have aimed to demonstrate insight into the role I have as researcher which can be viewed a strength but also a limitation in terms of the lens through which I have understood the data. This is explored further in the Discussion chapter.

In summary, this chapter has outlined the research theory that underpins the research design and detailed the ethical challenges and approach to gaining ethical approval. The sampling strategy and issues around access were discussed and the barriers around recruitment. The challenges around access and recruitment were explored, and the changes in terms of the data that was collected. A summary of the key learning from the Pilot Study was outlined including the ways in which this impacted on the ongoing fieldwork, responding reflexively to the issues that were raised. Finally, the analytic approach was described alongside a rationale for the choice of this method.

Chapter 4: Findings

The following two chapters distil the 60 hours spent observing AMHP practice and over 16 hours of interview time, via eight AMHP interviews and one Key Informant interview, into the key themes that emerged via the application of Reflexive Thematic Analysis (Braun & Clarke, 2022).

Chapter 4 sets out the context for AMHP practice, gathered via the observational data, setting out how the decisions that Mental Health statute and Codes of Practice require them to make, are accompanied by a raft of further decision points during the day.

Chapter 5 presents key themes from the data, largely drawn from the Interview data, which need to be understood within the context presented in Chapter 4.

4.1 Structure of the chapters: a rationale

When arriving 'on shift' for an AMHP duty day it is usual that the unknown looms ahead. The nature of AMHP practice is such that they are expected to be ready to respond to a crisis. For example, even when the AMHP may have awareness of an assessment that is likely to take place, another, unexpected situation could arise that diverts the AMHP onto another task. This uncertainty became evident early in the observations, and as will be explored, within the interviews with AMHPS. To reflect this sense of uncertainty and unpredictability I have set out the first part of the analysis along the lines of the AMHPs day, in order for the data to tell the story of a day in the life of an AMHP. Broadly, this is the activity that takes place in their work base, prior to receiving a Mental Health Act assessment referral, what the AMHP does once the referral is received - responding to this request. Next, I consider the data around the 'doing' of the assessment, meeting with the person who is being assessed, or journeying to meet them.

Arguably, the data generated to explore the research questions is rare, as there is a scarcity of research data that considers what AMHPs do in everyday practice rather than how AMHPS talk about what they do. As was discussed in the Methods chapter, the process to gain ethical approval and then access to participants, was time consuming and challenging to navigate. Thus, to do justice to this data exploring a hard-to-reach area of practice, and in evidencing with integrity the work that the participating AMHPs carried out, I have taken the decision to clearly differentiate between the observational data and the interview data. Chapter 4

outlines this observational data to tell the story of the AMHP participants' work and illustrate the journey that they take during this day. Similarly, to setting out on a long journey and choosing one route over another, the analysis suggests that the path that the assessment takes can be influenced and changed by the decisions the AMHP makes. To answer the research questions, it is therefore necessary to set out what these decisions are, the factors that influence them and how AMHPs synthesise information to enable them to make a decision. This section sets out the themes that were identified via the early analysis of the data, through use of the reflective memos, and provides opportunity to shed light on the verbatim dialogue that takes place when the AMHP is carrying out their role. The next chapter then explores what AMHPS say about what they do - gathered via the reflective interviews. This will connect to the themes that were elicited during the fieldwork, which provides the context for decision making. Structuring the presentation of the findings in this way reflects how the reflexive analysis was taken deeper in handling the interview data, as the interviews concerned the AMHP talking about their practice in a reflective space (the interview environment). Arguably this led to richer data being elicited around how they perceive the motivators and values that inform their practice and decision making.

In summary, the first chapter will demonstrate some of the thematic connections in the 'Day in the Life of an AMHP' as told via the observational data, setting the context for the AMHP role. This outlines the stage of the day when the AMHP is waiting to receive the referral and makes decisions as to what happens next. The chapter then goes on to outline what happens when the AMHP leaves their office base and journeys out to the assessment.

The next chapter will demonstrate the identified themes within the interview data, exploring AMHP reflections on what they do: 'What AMHPs say they do'. This chapter includes analysis of the Key Informant Interview, threading this analysis through with the AMHP interview data analysis.

A final summary section will pull together the two chapters as a reminder of the key themes that were identified through the data corpus, presented within the analytic framework of the AMHP journey, which is then explored further in the Discussion Chapter.

The themes generally represent the views of the AMHPs as a whole, in terms of how data was identified during the analysis within each observation or interview that shared a view that

contributed to the themes. Where there was a distinctly different voice or view this is highlighted as an exception, for example in the case of an AMHP who had particular views about the impact of experience on effective decision making. There were so few instances where this was notable that all occasions are presented within the findings.

4.2 Themes (and sub themes):

- Managing Uncertainty (AMHP wellbeing and resilience)
- Spaces and Places (Context and the impact of emotion on decision making)
- AMHP Motivation
- Professional Identity (Professional discretion, practice wisdom, knowledge, skills, and traits)
- Values and ethics: the lens through which decisions are made
- Power and Powerlessness
- Being Human

A note on use of the data: All identifying data has been removed but an attempt has been made to provide a close an account of events as possible without compromising confidentiality of the individuals whose MHA assessment forms the basis of some of the narrative from the AMHPs. The presentation of the analysis and findings would have been different had consent be gained from all those present at the assessment, such as the AMHPS perception of risk and how this informs decisions.

4.3 A Day in the Life of an AMHP: The Context within which AMHPs make decisions

Introduction:

The analysis of the data has led to my proposal that the work undertaken by an AMHP can be considered a journey whose destination is known but the route is not. The analogy of a 'Route Unknown' journey will be used to ground the analytic outputs. Some key details about the AMPHs role have informed the selection of this analogy based on descriptors offered by the AMHPs when talking about their role and working day. It is also a useful analogy to understand the sometimes-circuitous nature of the role and the barriers that can be encountered due to both contextual and internal obstacles. These includes resource

limitations and the emotional state of the AMHP. To set the scene for this journey, the AMHP role is constrained by time in that the work they carry out is reactive. This can be considered the point at which they are sat waiting to turn the engine on and set off on their working day. They receive a referral due to an individual presenting in apparent crisis, with the referrer having reason to believe the person may require compulsorily admission to a psychiatric hospital. The key focus to the role, upon which all action pivots, is resolving the crisis that is outlined in the referral information. This 'resolution' can be considered 'the destination' and it is typically hoped to be achieved on the same day that the referral is received. Whilst the crisis may be deescalated during the AMHPs workday, the pressure of achieving an outcome quickly saturates the AMHPs day. Using the analogy of a journey to present the findings of the analysis captures the uncertainty and reflexivity demonstrated by the participating AMHPs. The AMHP is clear that there is a journey to undertake, but it can be considered an unknown journey in that the destination is not certain. The AMHP also does not know which passengers they will collect along the way in terms of the other agents involved in that day or that crisis. There may be obstacles, delays or barriers which will require navigation. AMHPs also have a 'rules of the road' in the Mental Health Act and accompanying Code of Practice, which they must try to follow, although their 'driving' must be responsive and flexible to the context. This journey analogy therefore seems a useful one to ground and make more tangible the AMHPs experience of decision making.

4.4 What AMHPs do' and the context for their decision making: Receiving the referral

To tell the story of that working day, the following analysis is framed as the methodical tasks that the AMHP works through in their role. As will be illustrated, the journey is not in fact linear, with a clear route to the end point – external factors such as the availability of resources can impact on the course of the working day. But by first setting the scene and presenting the data as 'A Day in the Life of an AMHP', a sense is gained of the 'chaos' of the role, which is developed as the theme '***Managing Uncertainty'***. The analysis identified that Managing Uncertainty is a key aspect of the context for AMHP decision making as they work to resolve issues around the logistics of the assessment, and synthesis information to make decisions around use of the Mental Health Act. This theme sheds light on how AMHPs

manage uncertainty in their day. It encompasses the sub themes of AMHP ambivalence, wellbeing, and resilience.

The AMHP participants worked across a range of teams and settings and the observations of their day to day practice were carried out in a range of locations, usually commencing at the start of the duty day for each AMHP, around 9am.

Three of the participants shared an office in an old building in the city. Their work included Mental Health Act work but also covered other more 'generic' Social Work in their local area. Whilst I was with this team there was frequent discussion about the long term fate of their work base as it was widely acknowledged that it needed a new roof, it was drafty, needed re-decorating, and was hot in the summer, cold in the winter. This seemed in some way to be part of the identity of the participants as they told me about some of the foibles of the building but spoke with affection about it. As an observer, with my own experiences of being part of team (also in an old, on-the-cusp-of-being-condemned, public sector office) it seemed to me that the team were close, sharing anecdotes of their home and family life and using humour, particularly 'gallows humour' to pass the day. The setting for the team reflected a sense of working against the odds, within a poorly resourced service – a team coming together in shared adversity. Much of the data presented in this section explores how that team base, proximity to colleagues, interface with managers and other professionals, influenced and impacted upon the AMHPS practice in terms of their decision making, and their approach to the role.

During their duty day an AMHP can expect to receive a referral for a Mental Health Act assessment at any time up until the end of their 'shift'. Once a referral is received, even if that is towards the end of a 9-5 'day shift', the AMHP would often be required to work late into the evening if necessary. A referral would be received where the referrer has concerns about an individual's mental wellbeing and that there are sufficient reasons to consider admission to hospital due to the apparent risk of harm to self, harm to others, or of deteriorating health. By definition that person is likely to be at a point of crisis. The AMHP is the lynchpin in deciding what happens next.

On occasion they can pass this on to the emergency 'out of hours' team but the implicit expectation is that once a referral has been accepted and work has begun, that the AMHP

continues with this piece of work until its conclusion. In other terms, they hold the risk associated with the assessment until a satisfactory outcome can be found.

During the AMHPS working day they may or may not receive a referral. In the next section of this chapter I explore the data around this generated by the interviews with AMHPs. Participant D termed the time waiting for a referral to come in as '**the waiting game'**. More broadly this can be described as '**Managing Uncertainty'.** At this stage in the day the AMHP does not yet know if their 'journey' will commence. They are in the parking lot waiting for further instruction.

4.5 Receiving the Referral - Managing Uncertainty: Ambivalence and the 'tipping point'

During the observations the participating AMHP received a referral on each of the days I was with them – although not all of them led to an assessment e.g. a bed could not be identified and on balance the AMHP decided not to visit due to the perceived risk around heightening the anxiety of the person being assessed, or there were issues in identifying a second doctor. One AMHP was asked to arrange an assessment outside his usual geographic location as the AMHPs on duty in this 'patch' were all already busy with other Mental Health Act work. Other scenarios emerged which this section and the analysis of the interview data will explore. This extract of dialogue between two of the participating AMHPS evidences the dilemma experienced when they received a referral later in the day, after all the other available AMHPS had already been called on:

PC: I'm the last AMHP standing, everyone's out so no doctors available. It's a very busy day for MHA assessments. [There's] no bed, maybe after 2, but she won't let anyone in but will come willingly to her mum's to be seen

PA: Hold onto the no bed thing.

PC: Do I start ringing round now on of chance?

PA: If you don't, you'll be screwed at 2pm trying to sort it out.

There is an ***ambivalence*** evident – 'hold onto the no bed thing' i.e. that the AMHP might not be able to go out on the assessment, alongside the knowledge that arranging an assessment

can be complex and time consuming. The AMHP reflected with her colleagues that some days she feels OK about being called out late, but that evening she had a social event she really wanted to attend. The analysis also identified a spectrum of perceived 'difficulty' in terms of the type of assessment that was received. For example, one AMHP described receiving an assessment on a hospital ward as '**not too bad'** as the 'unknowns' were reduced. It was certain that the person being assessed would be present, and one of the doctors had already seen the person to complete their part of the MHA paperwork.

There seemed to be a '***Biting point'*** during assessments–when the 'engine' is sat idling waiting to start accelerating once it becomes clear the assessment will go ahead. This was linked to factors external to themselves, such as the availability of a doctor to accompany them on the assessment, or the likelihood of a bed becoming available were one needed. Once the decision had been made that they would continue with the assessment, this ambivalence diminished – they stepped into 'action', and their journey began.

The interviews shed further light on this ambivalence which I explore in the next chapter. What became apparent throughout both sets of data in terms of ***managing this uncertainty*** was that this was a stressful element of the job, that the participating AMHPs at times felt at risk, or uncertain of how their day might pan out. The main concern was an impact on their personal life – for example, working beyond their usual hours, potentially being alone in an unknown location such as an individual's home, waiting many hours for an ambulance to arrive to convey that person to hospital. Initial ambivalence to the assessment seems to be a coping strategy for managing this stress and anxiety – an underlying hope that the assessment does not need to proceed.

Early on in the analysis as I explored this sub-theme I reflected if I was looking for the data to tell me this story as reassurance from my own days of AMHP practice – a prevailing hope I always held when on duty, that I might not actually be required to go out on the assessment, alongside my enjoyment of the role, and a motivation to practice as an AMHP. However, this paradox was echoed throughout the data sets –as it became apparent that AMHPs had preference for assessments in certain locations, at certain times of the day which they clearly articulate, whilst also speaking with pride about fulfilling the role. This ambivalence does not seem driven by an unwillingness to undertake the tasks required of an AMHP but it does

appear to reflect the ways in which AMHPs protect their own wellbeing and bring a sense of safety or control into their working day. It does not impact on their sense of duty to the individual who is being assessed. The impact of the AMHPs emotional state on decision making is explored further within the interview analysis. The AMHPs perception of the task ahead and the ways in which they mitigate the stressors they experience as a consequence of these tasks, has relevance to decision making in terms of their capacity to carve out the reflective space they need to make 'good decisions.

Discussion between AMHP Participant A and Participant C on another occasion further evidenced this ambivalence, in this situation there was some suggestion the AMHP was hoping that a bed would not be identified, as this would make it less likely the assessment would go ahead:

PC: He [the psychiatrist] doesn't think we should go out until we have a bed…

PA: It would be rash if not foolish to go out before a bed is identified

PC: Will we need the police? He's just going to chase them [the bed managers] up now and ring me back

PA: They sometimes rustle them up annoyingly [an inpatient bed]

PC: They might say go and assess and wait for a bed

PA: But were you not listening, the consultant said look for a bed first

PC: [reflecting on the situation with PA] if its hospital [it's OK]….it's messy in the community, I'm taking someone along. If my phone rings say I've died or gone out..

In addition to shedding light on ambivalence towards the task, the AMHPs discussion reflected some of the tension experienced when a referral is received in terms of the potential barriers they might face. In this scenario there were risk issues associated with seeing the individual in their own home, without having first identified a potential bed if admission was assessed as necessary. The AMHPs joke about what to say if her phone rang whilst she went to make a coffee, evidences some of the 'gallows humour' I observed, but also a sense of trust and rapport between the AMHP colleagues. This suggests AMHP sought out emotional

support to manage the uncertainty and tension as each could empathise about the difficult situation they were experiencing. This could be characterised as an 'off the record' remark, unlikely to have been elicited via an interview.

The AMHPs also spoke about the ways in which the Duty Manager can help to alleviate the anxiety of the uncertainty around the role, but also increase this anxiety. As will be explored in the next chapter, perceptions around the support available via the Duty Manager had implications for the AMHPS **emotional resilience and wellbeing** when talking about the role and their longer-term view around continuing to work as an AMHP.

An example of this interaction with a manager occurred during observation 3 with AMHP participant C when, having ended a call to discuss a complex referral with the duty manager she stated to her colleague:

'Fuck off – X says they've detained her but X boasts about how few they've done…'

This suggests the AMHP has a lack of trust in and respect for her line manager, traits which did seem to be present in the interactions with her peer. This also suggests that there are characteristics that make a working relationship more supportive.

Support from colleagues including frank and open conversations were evident between the AMHPs based within the same office. This support seemed to be valued more highly than support from the management team. For example, I observed Participant C seeking reassurance from her colleague that the steps she had taken to hand over the assessment to an AMHP on duty the next day were sufficient. This was despite having also spoken to the duty manager. Another exchange evidenced this openness between colleagues – using quite flippant language within a trusted relationship that I did not observe her using when fulfilling other aspects of the role:

AMHP C: Why isn't this straight forward?

AMHP A: *It is relatively*

AMHP C: I just wanted to go the community, see mad lady, sign my paper

This reflects the different 'roles' the AMHP takes on and the different dynamics within the varying professional relationships they hold. Perhaps this was also an honest glimpse of some

of the personal feelings towards the AMHP role and the ambivalence about the role reported earlier.

Participant A spoke to me about the AMHP role in terms of the support he receives to fulfil the role from others, during my first day of fieldwork with him:

PA Observation 1: '***The whole of social care and the NHS would collapse if it wasn't for good will***'

This comment was made in the context of talking to me about the AMHP rota and how there is no set rota to seek support and 'back up' when going out on assessments, particularly in the community. He spoke of his reliance on networks and friendships to provide practical and emotional support and learning how to prioritise other work commitments when juggling the AMHP role.

4.6 Motivation, professional identity, values, and ethics

A sense of duty was identified as a sub theme in terms of the standpoint that the AMHPS brought to the role. Despite the pressures experienced as a consequence of managing uncertainty, the AMHPs, the motivation to fulfil the duties of the role seemed to be driven by a clear sense of duty to the person who was being assessed.

PA articulates this as '***do to someone else what I would expect for me'***

Whilst the data elicited this theme more explicitly during the observations of the face-to face assessment with the individual, it was threaded throughout the preparatory work the AMHP undertook to plan for the assessment.

This sense of duty and the need to manage uncertainty linked into a third theme identified, that of ***power and powerlessness*** for the AMHP.

4.7 Power and Powerlessness

In terms of the statute the AMHP has the legal power to decide how to proceed once a referral has been received. There is a duty to assess but given some of the contextual issues as outlined above, this was not always taken for granted given the dilemma that was prevalent during the fieldwork. The AMHP also must consider the current legal status of the person who has been referred for assessment. During a telephone conversation with the authority

holding an individual for further assessment the AMHP asked on what grounds the person was being held:

OBS11 PA: A to C: I like that man. What's the legal basis? The 'making it up as you go along' Act – it's refreshing!

This suggests a pragmatic approach to an assessment held at a police station where it was not clear if the Mental Health Act or Police and Criminal Evidence Act were being used as the legal basis for the person to be kept in custody. It also demonstrates where situations in practice deviate from the statutory framework with professional discretion in use from the police officer.

All the participating AMHPs shared their views regarding a lack of bed availability – in addition to difficulties in identifying doctors to accompany them on the assessment.

Once the referral has been received there is a period of time when the AMHP has to decide on the next steps. When the AMHP receives the referral and the 'tipping point' has been reached (that it seems feasible logistically to plan the assessment that day) they then move to the next stage where they commit to the assessment and begin to take action.

The action can be broken down into three key elements: locating a bed, establishing more information about the person being assessed and liaising to identify one, sometimes two, 'Section 12' doctors to accompany the AMHP on the assessment. However, other tasks can also arise. For example, during Observation 2 with AMHP participant A his first words upon reading through the referral were '**Oh, a dog'** – it is the AMHPs duty to ensure that any animals that a person may own (from a goldfish to a horse) are safely accommodated in the event of admission.

The possibility of a bed was the most cited barrier to commencing the assessment. During one duty day Participant C received a referral that had been handed between duty AMHPS over six days. She was advised not to start planning the assessment as there were a further five individuals also waiting for an inpatient bed. She discussed the situation with a colleague:

PC Obs 1: What are you supposed to do? Wait until there's a bed and then start ringing round?

Colleague to Pc: so no-one's been to see her? She's been seen by the crisis team though?

PC: Someone tried to assess on the [date] but she left the flat moments after they arrived. I've passed to EDT [emergency duty team] – they promised a vulnerable adult welfare check and the son has advised we wait for a bed before going out.

Participant C then made another call to the son to update him – my reflective memos note her sense of frustration and apologetic tone during this call.

The dilemma as outlined above, that seeing the person without the assurance that there would be a bed if needs be had the potential to increase risk for the person, is explored further within the interview data.

During one observation the AMHP experienced a dilemma around the most appropriate route to address the concerns that were outlined in the referral. Due to some accompanying physical health issues for the person who was due to be assessed, the AMHP was required to liaise with a wider group of medics and negotiate timescales for the assessment based on the outcome of physical health checks. The psychiatric ward would not admit her until physical causes for her presentation had been explored and ruled out and there was some dispute between the GP and psychiatrist as to the best course of action in terms of addressing the medical concerns. The AMHP articulated the dilemma during a conversation with one of the assessing doctors:

t/c to 2nd doc – I can't decide what to do. She sounds detainable but not sure if you put on your recommendation where to go to [psychiatric or physical health ward]. GP and 1st doc don't think she needs physical, but Dr X wants her to otherwise she'd have to go to the psychiatric ward, then be transferred, then back again. She'd still need detaining as doesn't have the capacity to go to the physical ward. Give me 10 mins, just waiting for my manager to ring me back.

To me: Part of me thinks, just go, she needs the assessment completing (was going to say she needs detaining)

To me: If this comes to nothing I'll have wasted all morning on it.

The dilemma included how to manage the logistics of the section paper in that the doctor is required to include the address of the place of admission. The AMHP needed to decide whether to proceed with her assessment or to wait for the outcome of the blood test which could have been a day or two. The frustration in the time this was taking is also illustrated well in this example.

Participant C Obs 6: T/C to her duty manager – giving overview, CPN knows her unwell, really common to deteriorate quickly, refused to give consent to community ECT. GP saw, Dr saw, made 1st rec, set up, Nearest Relative happy. All ready to go and spoke to Dr X, he said she's physically deteriorated quickly and wants checking physically. Dr X wants this before she comes in given risks – physically frail. Bloods taken 15 mins ago. The surgery sys 24 hrs, the other Doctor says 4 hrs. Once the results are in…sounds detainable, flat, not eating, drinking. Do we sit on it? She's in a nursing home so could do under the Mental Capacity Act – physical? There is a bed, the 1st [medical] rec has the psychiatric ward on but he could change that. What I thought was..I could go out…do the form and put 2 hospitals, 1st Dr could change his. Just checking on dehydration if she still needs a physical bed. Worst case, admit under capacity act, there a couple of days and then detain her to the psychiatric in a few days. Ok, cool… She's thin, frail – her physical health breaks down. Go and do it, doesn't change the outcome.

t/c to first Dr – we'll need to make a decision about 4 – can she be left another day pending bloods?

In this scenario the AMHP appears to frame the decision making within logistics of seeing the person before a bed has been identified. By drawing upon resources and talking through the potential for not doing the assessment she concludes that the assessment should go ahead.

During all the observations, securing the agreement of a doctor to carry out the assessment also led to delay and uncertainty for the AMHP.

During one observation Participant A had to make a number of phone calls to make contact with the psychiatrist who had made the referral. His aim was to add to the brief information he had received when the referral was made:

PCA Obs1: ***This is what I find most frustrating – not being able to get hold of anyone, you can't make informed decisions***

Across the observations this was a recurrent issue of lack of access to information. Either the AMHP could not access all electronic records (such as NHS records when based in a local authority team), or sparse referral information, articulated by Participant A during this observation as '***a dearth of info'*** - alongside the difficulties in contacting the referrer or other involved workers. Participant A initially took a critical stance towards the referrer – not immediately accepting the narrative of risk as outlined in the referral information, nor the need for admission. This appears to relate back to the ambivalence stage of the assessment when the possibility of not acting is still being considered. It also reflects some of the powerlessness experienced by the AMHP. One participant articulated this during an assessment:

PC Obs2: 'I'm scuppered'

My reflective memo states shortly after this comment:

PC starts looking at a job on the internet whilst waiting on the phone

This reflects some of the push and pull experienced by the AMHPs, the motivation to continue in the role alongside actively questioning why they continue to do it. This sits within the theme of **Power and Powerlessness** in terms of the frustration experienced when not being able to fulfil the role due to external factors.

In terms of collating information once the referral has been received and the assessment and action underway, several issues were identified that suggested that the AMHP categorises information to support or challenge the dominant narrative presented in the initial referral. For example, PA reflected with a colleague on the quality of referral information he had received, suggesting that due to previous knowledge of different practitioners he 'trusted' the information of some over others. This could be considered a hierarchy of knowledge that he considered when synthesising the information around the assessment and his decision making:

PAObs 1 (comment to colleague) The ward manager couldn't tell me anything. They're suggesting he's resisting being in hospital, what's the info? No one has a clue…the psychiatrist is bang on it with the MCA [Mental Capacity Act], will take time out and not brush me off. When you get something from him you know it's not going to be…not just using the Mental Health Act to make their life easier rather than it being necessary'.

Participant B greeted me at the start of a later assessment with the words:

PBobs1: I've never had 4 files on this table before, it's just awful. I finish at 9 (pm) but can't see that.

This AMHP had received 4 referrals for Mental Health Act assessments, on the same evening and described it as 'spinning plates'. This setting amplified the uncertainty that is inherent in the role and evidenced the AMHPs need to prioritise and synthesis information on different individuals at the same time, to decide which task to focus on first. This scenario only occurred once during the fieldworks (i.e. that an AMHP received more than one referral on that day). However, even when dealing with just the one referral the data revealed the 'juggling' that the AMHPs undertake. The interview data referred to the setting up of an assessment as completing a '**jigsaw puzzle'.**

4.8 The impact of Space and Place: the role of emotion on decision making

Whilst the other observations saw the AMHP based in the relative 'safety' of a team office, this AMHP was working within a setting where people were conveyed for assessment – for example individual's assessed under Section 136 of the Mental Health Act, where the police had concern for a person's mental health and immediate safety. I sat with her in the office based on the hospital site, a room down the end of a corridor clearly visible to anyone that was within the unit. One distressed person was walking up and down the corridor, face to the glass looking into the office space that the AMHP and doctors used:

PB Obs 1:'The design of this place is not good, it's like a goldfish bowl. It's not safe'

Therefore, for this AMHP in this situation there was the uncertainty of managing multiple referrals, layered with being situated within a place that felt unsafe, raising the stress levels of that AMHP. Although she articulated feeling stressed and under pressure to me as an observer this pressure was not evident. She presented as calm and methodical as she worked

through tasks. I observed this AMHP making calls to family members to gather further information about the individual she was due to assess. Outside the room there was noise and distraction due to other distressed people being present at the unit. The AMHP was making plans to see the individual she was due to assess on another part of the hospital, outside the '136 suite', discussing this with colleagues:

PB Obs 1: 'I can't assess properly with a woman shouting outside the room – I've rung [the other ward], they need 5 minutes to think, worried about it being a place of safety. I explained a place of safety can be anywhere'

This extract evidences professional discretion and legal knowledge, but also the backdrop of the working conditions AMHPs are placed in. Making decision within emotionally charged environments.

I observed this AMHP on another day when we were due to meet for her interview. Upon my arrival she stated that it was quiet so far and asked me to wait whilst she completed a task. A short while later this had changed:

Extract from reflective memo:

The day I was due to interview her she was doing another long shift 8.30-9. I arrived and was told all was calm, when I saw her she was dealing with three assessments:

1. A v distressed woman on 136 from abroad, partner flying to join her and staying locally

2. An under 16 'I told them, no, keep them on the ward (when it was suggested to bring them to assessment unit)

3. Someone on assessment unit, medical recommendation done the day prior, already looking for a bed

Discussion with colleagues re bed – how to prioritise, partner would struggle with accommodation etc, discussion with doctor, negotiation, treading carefully.

Prioritising the child ' I'll need to read up (on MHA) before I see them (due to age group)

It is the nature of the role for an AMHP based within a crisis team that they are likely to receive numerous referrals. This example sets the scene for the interview data that explores how AMHPs manage this task.

4.9 Professional Identity

Observing the AMHPs I became aware of their use of interpersonal skills when making arrangements to set up the assessment, especially during telephone calls. These sit within the theme '**Professional Identity'**. For example, the two AMHP participants who I sat alongside and observed the conversations between the two, markedly shifted their tone of voice and use of language when making calls to different people.

During one observation Participant A made calls to 8 different doctors before one confirmed they would attend. During another observation 6 doctors were contacted before one agreed to attend the assessment. I reflected with him on how he had apparently maintained his patience throughout this lengthy process. He replied;

PA Obs 1: 'I try and be human and personable'

During another Observation with AMHP Participant A he called 20 doctors before one agreed to attend:

Data Extract: Identifying the Section 12 Dr:

1. ***I'm ringing re an assessment in….. CANT DO***

Let's give Dr X a ring – out of her way though as other side of the city, might not be overly keen to do it.

PA to me: See because I'm the last AMHP called out all the other Dr's will be busy

2. ***t/c to S12 – NO (4th call he's had)***
3. ***Dr Y– he's usually keen but bet he won't come out – NO CANT***

Reflection: geographical considerations an additional barrier to getting a Dr)

4. ***Bet he won't come out either but I'll give it a go – NO ANSWER***
5. ***NO ANSWER***
6. *Tone of voice, half expecting him to say no* ***– no fair enough, thanks anyway***

7. *Tone – more upbeat* ***'Thanks anyway***
8. ***Are you interested or available? NO***

Reflection: an exercise in persistence and patience

9. ***VOICEMAIL***
10. ***NO ANSWER***
11. ***NO*** *PA to me:* ***there is a rubbish Dr, I'm getting a bit desperate, I know she'll be available, she's retired.***
12. ***NO ANSWER***
13. ***NO***
14. ***NO ANSWER***
15. ***NO ANSWER***

PA to me: Pool of 40 possible's but some restrictions when they can come out.

16. ***NOT AVAILABLE***

Reflection: PA remains polite throughout, doesn't let his frustration? Show

17. *NO ANSWER*
18. *CANT DO*
19. *NO ANSWER*

PA to me: no bed, no doctor…that's the way it goes

t/c to crisis: ***so what do we do? Try again tomorrow? You're thinking there isn't going to be anything..***

*PA to me****: no beds in the whole country. I'll keep trying Dr's cos at least then we'll have two RECS***

20. *YES!!!*

Participant D made a comparison with 'haggling' when on the telephone to one doctor, explaining what was needed to be done before he was free to carry out the face to face assessment, in order to compromise on a time to meet. This was the second call the Doctor has received that day in relation to a request to attend a Mental Health Act assessment:

Participant D Obs2: You probably know why I'm ringing then…[use of humour[that's where I am ….I've got a medical rec I need to pick up, they went out but there were no beds. I need to pick up a med rec from crisis all the way to the [hospital] and back so how about 1.30 12.45? (negotiating based on their travel times) This is like haggling isn't it…I'll set off now'.

During the process of locating and confirming the doctor's attendance there were two, at times competing factors the AMHP considered. They spoke of their preference for certain doctors, but that given the scarcity of available doctors during the period the fieldwork was conducted, there was a sense of accepting whoever is available. There was a sense that practitioners at times take pragmatic steps to manage a situation, whilst demonstrating a value base that critiques what can be considered the traditional dominant paradigm within mental health services:

AMHP Participant A: One Dr – the past 20 years in psychiatry seem to have passed her by – you know that authoritarian manner – she was trying to wrap things up..'if you want to go now no one will stop you from leaving'..

One explanation for the lack of available doctors was the increase in other statutory work, specifically the Deprivation of Liberty Safeguards which had seen a huge increase in use due to a significant change in case law which broadened the definition of 'deprivation of liberty;:

PA Obs 1: 'There's problems getting a Section 12 doctor as they're on the DoLS gravy train, there is a preference to do DoLS, the Mental Health Act is messy and long winded'

This had the potential to impact on the final outcome of the assessment, according to some of the participating AMHPs:

PA Obs 1: Statement to researcher: Dr X would have come out but as he's more thorough I've gone for Dr Y instead. He'll have read up on [the electronic medical records] and come with some background knowledge. Some don't know anything and take a cursory glance at the notes and then you almost see them filling in the section papers in their head before the assessment'.

The Code of Practice states it is best practice for a doctor with 'prior acquaintance (REF) to make one of the medical recommendations for admission. In practice case law has clarified that prior acquaintance can be considered any doctor who has access to the person's medical

records. They do not need to have met face to face. In some cases, this might suggest that a GP is best placed to assess, alongside a doctor with specialist mental health knowledge.

Participant A reflected on this during one observation:

PA Obs 1: 'The GPs probably not going to come out. They do sometimes but it's rare – they do sometimes as out doing a domestic visit. I give them a call more in hope than expectation – they'd have to come from A to Z and will have other things to do. I'll leave a message and then they don't get back to you and in the meantime I could be sorting out a Section 12 doctor'.

This extract also highlights the application of policy to practice. This is what the Code of Practice states an AMHP should do. This is what happens in reality.

During the second observation of Participant A a scenario arose that encompassed a lack of referral information, being unable to contact the referrer or anyone who knew the individual well, and knowledge that on the previous day another AMHP had tried to contact 18 doctors before one agreed to attend to assess. This extract is a telephone conversation to the team where the referring psychiatrist is based, in conversation with the duty worker for that day:

PA Obs 2: The problem is I've got this referral in, looking like Dr Y wants to go out at 3.30 and he's going to make a sec 2 recommendation without ever having met her. [There's] quite a lot of gaps on the referral see, if I wait another hour you see – is there no one else about? Your team has asked me to complete a MHA ass so I'd have thought so'.

My reflective memo noted:

The AMHP is very calm, matter of fact…not engaging in ante-upping, taking the stance there may be no concerns.

This evidences to some extent the AMHP taking a position in terms of putting the accountability for demonstrating grounds for considering use of the Mental Health Act, back to the referrer. This can be considered an example of the AMHP taking control, or asserting power, over the situation in terms of pacing the assessment, pausing before taking the next step to ensure more information was gathered to inform decision making. The themes **Power and Powerlessness** and **Professional Identity** in terms of professional discretion overlap to some extent.

4.10 Professional Identity: Professional Discretion

During the observations I noticed the 'gear changes' that the AMHPs experienced. The 'waiting game' prior to receiving the referral, the ambivalence in terms of gathering energy to take on the challenge of arranging the assessment, and then 'going out' on the assessment. At times this energy was diverted, for example if a barrier emerged that led to the AMHP being unable to take further action. At all stages the AMHP is required to make a decision as to what occurs next, such as ways in which to resolve any obstacles that arise.

For example, during Observation 2 Participant D had arranged a time to meet the doctor to carry out the assessment but the assessment was postponed due to there not being any available beds. It was handed over to the Emergency Duty Team. The AMHP was required to liaise with the son of the woman had been referred for assessment, an older person experiencing dementia, to update him on the situation. He was aware that the son did not want his mother to be admitted to a bed 'out of area' and during the observation he reflected on this dilemma stating:' T**hat's not covered in the code of practice'** in terms of how the AMHP resolves this resource driven issue.

The interviews explored with the AMHPs how they managed this 'gear change' in terms of stress levels – the 'action to inaction', and also walking away at the end of the day, leaving work behind. The second Observation of Participant D, the referral for the older woman experiencing dementia also identified the emotional investment in an assessment and perceptions of the experience for the individual being assessed. The AMHP had prior acquaintance with this individual and was aware that some of her beliefs involved a fear that 'people were coming to take her away'. He reflected on his role in potentially reinforcing this belief and that given pressures of bed availability it was a possibility the assessment would take place out of hours. During the duty day he shifted from gearing up to assess in difficult circumstances, to the dissatisfaction of handing the task on to the emergency out of hours team.

During the observations Participant A and Participant C discussed documenting the outcome of the attempts to set up the assessment that was thwarted due to the concerns about assessing without any suitable inpatient bed being identified:

PC Obs 3: [In the context of updating the duty manager on the barriers to assessment] he doesn't care though but at least I can write on the form I've told him'

This evidences some of the anxiety that the AMHPs described in the interviews, an a element of defensive practice to bringing back some control to what seemed to be circumstances outside of their control, or to regain some 'power' when feeling 'powerless'.

During Observation 6 with Participant C a further scenario arose when the results of physical health checks were delaying a decision as to where it would be most appropriate to admit an older adult. The AMHP was aware that the assessment may need to be handed over onto the next day's duty AMHP. She discussed this with her colleague Participant A:

Participant A: What's the plan?

Participant C: Get 2 recs and drop them off at crisis. Her mental health is unstable regardless of what comes back on blood results, needs to go to hospital, not going to agree to it. If by 4.30 no results, ring consultant about him and GP making a decision if she can stay overnight – they need to make a decision on that.

I'll hand it back to the rota – I'm on duty for our team

Participant A: Have you got a cast iron reason for doing that?

Participant C: I can't do that, I'm on duty, if they're not happy they can argue it out with (area team manager)

Reflective memo – Participant C also talking about an email asking if she can be available at 4 this afternoon and talk of new referrals (general background pressures of the job).

Here the colleague appears to be gently challenging the AMHPs decision making, with use of the phrase 'a cast iron reason'. The AMHP responds assertively that she will escalate these workload decisions to a senior manager. This was in a context of her talking about workload pressures increasing and an awareness that she was on duty for her own team the next day (for non-Mental Health Act related urgent work). This can be considered an example of decision making to protect well-being and resilience, knowing the limits of what is manageable and putting boundaries in place to take back some control of the situation.

In terms of the AMHP being accountable for decisions when the context limits the available options, Observation 4 with Participant A provided further analytic insights. This extract is the conversation the AMHP has with the son of the individual for whom there is concern. It illustrates the ways in which the AMHP shared information with the family member and took steps within the context of limited resources, to manage risk:

> ***'I've been given the case of your Dad to arrange a MHA ass, are you aware? Spoke to your sister..she explained both of you are mainly involved. Arranged to go and see your Dad at [time' with S 12 Dr (can complete MHA ass) to see if they agree with the Dr who said your father should be in hospital. There isn't a bed in [city], or the country. What we have to do – the team at X, they look for beds for us, they try out of area beds, they called me at [time], tried out of area but there isn't anything or the likelihood of one today. To put you in the picture, I know it's the evenings when your Dad goes to the pub – what time does he go out? It's a tricky situation, I'm not sure what we can offer, if there isn't a bed I can't section as have to put an address. Just thinking of what to…could you give your Dad a call tonight to check he's OK? Later on.. I can go out and assess and if Dr agrees he needs to be in hospital have up to 14 days to make an application – matter of that AMHP seeing your dad, there isn't much point until there is a bed but if we have 2 med recs your Dad can be detained. Tonight, ways of keeping him safe – you can't stop him, rather you don't come to the assessment but think…all I can do is apologise for a lack of provision as a family you can keep him safe when I've seen him I'll give you a bell and let you know what the second Dr has said.***
>
> *PA to me (as he put the 'phone down):* ***Walking away with your fingers crossed –that feeling when…what can you do?'***

It could be said that the AMHP holds power in this situation in that the fate of the man for whom there is concern, is within the scope of the AMHPs role to influence. The AMHP is enacting a statutory role and talks about the use of a Section of the MHA to detain. However, there is also a sense of powerlessness articulated by the AMHP, and honesty and openness in the information that is being shared – perhaps as a means of mitigating the loss of power. The representative of 'services' admitting that there are limits to what they can do. To return

to the theme of professional identity, the AMHP has to be accountable for unsatisfactory outcomes and actions (or inaction). They are the 'human face' of the barriers that exist when accessing mental health care in that the AMHP is responsible for liaising with family members (as well as the individual) to involve them in the assessment. How this dissonance sits with the AMHP is explored further within the interviews.

This tension is summarised in an extract from an observation with Participant A:

> ***PAObs4: on telephone ringing a family member (a LA employee) 'if he is one of us at least he'll be civil'.***

In summary, the observations within the AMHPs office base enabled the analysis of the data to shine a light on the circuitous nature of AMHP practice. According to statute the AMHP receives a referral and acts upon it to arrange and then carry out a Mental Health Act assessment. In practice, this next step is dependent upon the availability of other professionals, the location of an inpatient bed, plus the accessibility of information to inform the AMHPs decision making. The AMHP is required to manage uncertainty, experiences the push and pull of power and powerlessness (in part due to resource constraints limiting their scope), and is required to act autonomously upholding their professional identity. Each stage requires the AMHP to make decisions that taken in isolation might have minimal impact, but cumulatively demonstrate the power the AMHP has over the situation as this sets the scene for the next part of their working day – going out on the assessment.

This extract encapsulates a lot of those uncertainties and asks a key question around AMHP motivation:

> ***AMHP A to AMHP colleague (C) '[It's] really messy, don't know if we can get in, no beds in [CITY], sister pissed off and there a dog and no referral to crisis.***
>
> ***There's definitely one dog there but not sure if there's another***
>
> ***Why do we do this bollocks?***

4.11 Section 2 'Going out' on the assessment:

The analysis identified a clear shift in the AMHP role once they leave the team or office base and 'go out' on the assessment, developing the analytic theme **'Spaces and Places'**. This stage occurs once all the arrangements have been made to make the assessment happen.

The analysis elicited themes around the context for AMHP decision making in terms of the settings in which they are expected to make decisions. Data was also collected about the ways in which AMHPS speak with and gather information from the person being assessed. This sheds lights on if and how the Guiding Principles of the Mental Health Act are being applied – the framework for decision making as set out in the MHA Code of Practice.

These observations took place: in the community (at the home address of the person being assessed), at a care home, within a s136 suite, in an interview room at the police station custody suite, and on an acute psychiatric hospital ward. The setting for the assessment brought different issues for the AMHP and so this section of the chapter considers each setting individually. What was shared across all assessments was the time the AMHP spent 'face to face' with the person being assessed. This was the moment when that person's views are gathered and the AMHP assesses how they are 'presenting' via their verbal and non-verbal communication. This key area of decision making will be presented across each face to face assessment scenarios. For clarity, each section will include a table to indicate which themes are evident within the presentation of the findings.

4.12 'Setting off' – journeying to the assessment

Themes:

- Spaces and Places
- Managing Uncertainty – emotional resilience

It is of note that that the analysis identified that the uncertainty the AMHPs experienced in the office when setting up the assessment (preliminary enquiries regarding the bed situation, establishing who else would be attending the assessment), is amplified once they leave the team setting. The uncertainty could be considered an intellectual challenge in the office but once out on the assessment other factors are present such as lone working, risk issues and working in an unknown or unfamiliar setting. The AMHP interviews shed more light on the

anticipation and anxiety experienced by the AMHP prior to undertaking assessments, particularly in the community. The fieldwork data provides context regarding the nuances of what occurs during this stage of the AMHPs working day.

During two of the assessments I travelled in a car with the AMHP. This time spent in the car marked the transition between the safety of the office and the face to face element of the assessment. During one journey an AMHP participant spoke to me openly about an assessment she was able to pass onto a colleague as the presenting circumstances were 'too close to home' in terms of some events in her own life. The car can be considered a place for reflection as it is a time when the AMHP is thinking through what will happen next, but also a time to debrief or 'decompress' after the assessment – the transition from work to home. Data from the interviews will explore this transition further. My reflective memos noted that the time spent in the car with the AMHP felt more informal, with an openness about the day ahead. I noted if the participant was not consenting to data being collected during this task as they may not have perceived this was a part of their working day for observation. This reflected the shifting approach to ethical approval and consent which was outlined in the Methods Chapter.

The physical journeying to an assessment can add an element of uncertainty to the AMHPs day such as where to park – the hospital for example being notoriously difficult to find a parking spot causing additional delay. Participant C commented to me during one observation:

'You have to pay and display at the hospital, it adds to the stress'

I travelled separately to the AMHP on one occasion and was given parking 'tips' for finding a space close to the ward and instructions on gaining a parking pass from the reception. Insider knowledge that eases the barriers encountered in a working day. The AMHPs also spoke of not knowing certain areas of the city well, or there being traffic delays or road works. These layers of uncertainty felt important to note as further evidence of the challenging circumstances within which AMHPS are making decisions.

4.13 Assessment in police custody

Themes:

- Places and Spaces

- Professional Identity
- Values and Ethics

A further observation took place at a large city police station. I have visited several police stations in the course of my own social work practice, but these tended to be small stations with just a few cells. Stepping into such a large station with high security procedures was daunting, even with my previous experience:

> ***Extract from reflective memo: At the police station: Where did I sit – being pregnant, watching out for cups, risk to self as a researcher etc…not appropriate to take notes as he was suspicious, guarded, unpredictable, I was concentrating on keeping myself safe. Another person in custody became aggressive and I had to be ushered back into a room out of the way. How did I feel? Familiar with custody suites but smaller ones – this one felt more intimidating but also had better panic systems etc. I was so keen to get data maybe I didn't look after self as well as should have done.***

With the passage of time since carrying out the fieldwork and analysing the data this memo sheds light on the unexpected 'making the familiar strange'. At the time this setting was familiar to me, or at least not unexpected. Since stepping away from AMHP practice this memo led me to consider to what extent AMHPs become familiar with decision making under pressure – de-sensitised to the situations within which they operate and which may appear from the 'outside' to be situations of extreme pressure. The interviews explore this tension further – what motivates AMHPS to continue in the role. As I as researcher 'didn't look after myself as well as I should have done' what light can this shed on AMHP wellbeing and resilience? What becomes 'custom and practice' and what aspects of the AMHP role require further scrutiny to understand issues around recruitment and retention in the role for example. It is also of note that the decisions being made under this type of emotional pressure include decisions to deprive individuals of their liberty for up to six months.

During this assessment the person being assessed was seen in a small interview room, a panic alarm strip running around all four walls. He presented as agitated and distressed. Referring to himself in the third person and directing all his comments to the custody officer. The

assessing AMHP became an observer in some ways as the assessment felt tense, and unpredictable.

> ***Extract from reflective memos: Would have been more intrusive to leave after the assessment had commenced. I didn't take notes. A's main role – to listen – Dr took the lead, 25 min assessment. Sometimes nothing to say? What other options? A moved his coffee under the desk – risk management.***

The AMHPs make decisions in stressful working conditions, even when in a more controlled environments, such as a police station or hospital assessment unit, unpredictable elements prevail.

> ***PAObs: (t/c to crisis team): '[He's] way detainable, really unwell. Deteriorating mental health, apparently no risk to others. Police confirmed no record at all. He did talk, continuously but just addressed police officer, said he wouldn't speak unless he was there. Constantly in third person, quite bizarre. Grounds for assessment – certainly meets it. Police going to take him to [hospital] rather than an ambulance. Zero chance in the community'***

In this situation there was no ambivalence from the AMHP. The decision around use of the MHA – was the person 'detainable' did not appear to present him with any challenges. This aspect of the decision making was echoed within some of the interview data. By the time the decision needs to be made – whether to detain – there was often a sense that there are no other appropriate options but to admit to hospital. If there are limited options, the decision maker is thus limited in the outcome of their decision. This scenario is not uncritically accepted by the participating AMHPs as will be explored in the next section of the chapter and the discussion.

4.14 Assessment in the community:

Themes:

- Spaces and Places
- Power and Powerlessness
- Professional identity: Professional Discretion, practice wisdom

- Values and Ethics

The assessment location was a flat on a city centre housing estate. We parked in a small resident's car park outside the flats and met the assessing doctor. The AMHP was dressed casually but the doctor was wearing a shirt and tie, dressed more formally and clearly an individual 'at work'.

PA2: Reflective memo: Stood in the cold, talking about beds [with the assessing doctor]

We walked up to the flat and the AMHP knocked on the door but as there was no answer we went round to the back door. There was no evidence of anyone being at home, for example a television or radio playing, or lights on.

The AMHP called his manager to discuss the next steps, evidencing reflexive practice, or reflection 'in action' (reference Schon reflexivity etc):

> ***PA2:t/c to manager: Not 100% certain she's in and the problem is I don't want to shout through the letterbox as they're people about. Might be ideal for (full time AMHP) to run with next week. Might be unwell, might not be. I'm being quite careful about what to put on the note. Don't know whether or not to tell her we'll come back Monday. Potentially we could get a warrant so it's important she lets the worker in.***

The AMHP spent 30 minutes sat in the car making a decision about how best to word the note. He stated to me:

> ***You've got to try and put yourself in her shoes. Try and be as non threatening as possible'.***

The Reflective memo states:

> *Sat in the car with Participant A as he decided what to write to her about the warrant. This took 30 minutes, agonising over small decisions saying to me:* ***'for us it's just a note but if you're highly distressed you can unpick it all, the meaning'.***

The AMHP had a legal duty to consider use of a warrant which would be provided by a Magistrate and authorise the police to access the house. He weighed up the risk in terms of

her mental health of not seeing her, against the impact this intrusion to her privacy. The use of the term 'agonise' reflected how conflicted he presented during the observation when deciding how to proceed. He stated to me:

> ***Participant A obs 2: 'How best is it to tell someone what is happening? It might be more frightening not to explain, to be open about it'.***

This suggests that the AMHP is not just carrying out the legal functions required but is applying a value base to the decision making, considering the emotional impact on the individual, and also how to use the power invested in the AMHP role.

The assessment pausing as the person was not at home and it was then the weekend. In terms of resource pressures, the AMHP updated me the following week. The assessment had still not taken place 4 days later as there were no beds available 'in the country', the AMHPs comment reflecting a sense of powerlessness, using the analogy of a game of chess – being part of a wider system or 'game':

> ***Participant A: 'It's a stalemate'***

This scenario evidenced the 'inaction after action' that the AMHPS can experience, the pace of the assessment shifting from all the energy that goes into setting up the assessment but often leads to 'inaction' as there is no bed, or the person isn't a home once the AMHP eventually go out to assess. This sits within the theme of **power and powerlessness**. It is of relevance to decision making in terms of motivation to continue in the role and resilience to the barriers that can emerge when attempting to fulfil the functions of a role. There is also a question around the impact that these delays have on the person due to be assessed. This is considered in the Discussion chapter.

4.15 Assessment in a care home:

Themes:

- Spaces and Places
- Values and Ethics
- Professional Identity: skills, knowledge, practice wisdom, sense of duty
- Being Human

One assessment took place in an older person's nursing home. This setting enabled good access to records as the staff kept a written file around the person's care needs. The AMHP was able to speak with the carer who knew the person being assessed well, and they had the calm and privacy of an office environment to meet in. The Doctor was also able to be present to talk over the situation, and there was a lengthy conversation held which the AMHP led to summarise the situation so far and the risk issues present. The AMHP met with the person being assessed in her room, an older woman experiencing mental distress and eating and drinking very little:

> *AMHP Participant C: The Dr's are worried about your mental health.* ***What kind of place do you think it is?***
>
> *Person: The [PSYCHIATRIC WARD*
>
> *AMHP:* ***It's not [PSYCHIATRIC WARD] it's a care home. How long have you been here ?***
>
> ***What's your mood like – happy, sad? What do you think you've come here for?***
>
> *AMHP: Just a bit of…*
>
> ***Do you think you're poorly****? (C then helps her with her cardi)* ***The Dr's are bit worried you've not been having a lot to drink or eating..do you know what you've had to eat today? Yesterday you didn't drink anything at all. You haven't been letting the nurses change your pad either. If a Dr said you needed to be in hospital would you go?***
>
> ***Do you think you need to go in again****?*
>
> ***Who will think you're stupid (going back and forwards to hospital)***
>
> ***Dr's are worried about your eating and drinking so might be a reason to go to hospital.***
>
> ***Are you sat funny on it? (helping her with her cardie)***
>
> ***What do you think you've had a blood test for?***

My reflective memo noted that the AMHP used open and some closed questions to elicit information and the person being assessed made brief replies, some which seemed out of context to the question. I noted a warmth and concern in the AMHPs tone of voice, which

appeared to set the person at ease. She also used physical contact as a connection, resting her hand on her shoulder and helping her with an item of clothing that looked uncomfortable. This seemed to evidence some of the **interpersonal skills** used by the AMHP in setting the scene and attempting to form a rapport.

The AMHP discussed the outcome of the interview with the doctor. The doctor made a comment that he had felt he did not need to ask many questions to form his opinion. Whilst the person had limited verbal communication the AMHP stated:

I like to give them the opportunity (*in response to Dr re capacity – he said there wasn't much need to go on as she lacked capacity to consent to admission).*

She formulates her decision that the person does need to be admitted in these terms:

> *Participant C:* ***I can't see what else they can do for her here – given historical risk, we know about those, historically she relapses quickly. Not going to help her mental state.***

Again, it seemed that the alternatives to admission were already limited at the point the AMHP was required to make a decision around eligibility for use of the MHA.

The AMHP also displayed a sense of personal involvement rather than solely 'professional' in that she stated she was 'feeling 'better' as she knows the person being assessed had eaten and drunk a little, which reduced some of the risks outlined in the initial referral. The analysis identified this as the way in which AMHPs underpin their approach with a value base. The information they make sense of when making decisions being made through the lens of a particular set of values such as maintaining dignity and demonstrating empathy. This also had an impact on how the AMHP was left 'feeling' at the end of the assessment when she was not able to proceed with admitting the person to hospital due to the medical test results still being unavailable and thus a bed could not be identified. The AMHP made contingency plans, deciding on the best course of action but also expressed her frustration at the situation:

> ***I'll take the section papers back to crisis so if something happens later EDT can get hold of them – it's out of my hands, its pants! I hate ones like this***

AMHP to nurse: ***what will happen is, the AMHP will need to make the rec, see her again as I'm busy tomorrow. It's not going to happen today unless I get a call about the bloods. Tried to ring GP, it just rang, The blood samples have left the home – probably tomorrow. She has eaten and drunk and opened her bowels – that's a positive.***

There was a resolution of some kind in that the AMHP made a clear plan of action to be followed up, but there is the suggestion that a sense of unmet duty is present for the AMHP, even though this is driven by external factors.

4.16 Assessment on a hospital ward:

Themes:

- Spaces and Places
- Professional identity
- Power and Powerlessness

In this setting Participant A presented as relaxed and calm, having informal conversations with the ward staff and the assessing doctor. There was a sense of predictability in that the assessment took place in a side room on the ward, there was already a bed identified as the person was an inpatient. The AMHP was able to speak face to face with the ward staff to elicit information about recent days and was also able to read the electronic record for detailed daily entries and risk information. The remit for the AMHP was clear in this scenario – to speak to the person, consult with the Nearest Relative, and make a decision as to whether the criteria was use of the Mental Health Act was met.

Participant A Obs3 'We have clear evidence – slept for 5 hours in the last 3 days, offering out other patients, aggressive, playing loud music, masturbating in front of staff. Is he unwell? Does he come under the [Mental Health] Act? No insight, lacks capacity, possible risk to self and others, family called the police as concerned. I couldn't even explain why I was here…I tried three times.

The AMHP explained the outcome of the assessment to the person, in this instance there was an emphasis on the person's legal status and rights. The AMHP appears to make the situation

more tangible for the person by giving an example of how this deprivation of liberty impacts on the here and now for the person in terms of seeing family and leaving the ward for a cigarette:

> ***Participant A Obs 3: 'I've had a chat with the doctor and agree that its best if you stay in hospital under Section 3 of the Mental Health Act. Your choice whether you leave or not is temporarily taken away from you. You can still go out for cigs and visit your family if the doctor thinks that's OK. You've been detained under Section 3 which means that you have to stay in hospital for up to six months or if you disagree you can ask for a tribunal or a manager hearing. You can get free legal advice, a solicitor or free access to an advocate, completely free if you decide that'.***

This can be considered an example of how the AMHP uses the inherent **power** in the role and the ways in which this power is mitigated by ensuring the person is made aware of their own rights, or power in the situation.

In terms of setting the scene for decision making arguably a ward setting is conducive to the AMHP being able to focus on fewer decisions without the contextual pressures that being out in the community at a person's home could bring about. There are also fewer distractions such as thinking through if there is a bed, how to accommodate any pets etc. In simple terms, the AMHP has less to 'hold' in their mind when synthesising information to inform decision making.

What is less clear is the perspective of the person being assessed as the data did not shed light on this. Is there a bias towards deciding to maintain the status quo and make an application for continued detention? The person is not in their own environment and the imbalance of power could be considered starker in this setting.

4.17 Assessment in a 'place of safety' – Section 136 of the Mental Health Act

- Spaces and Places
- Managing Uncertainty
- Power and Powerlessness
- Professional identity
- Being Human

This assessment took place in the setting that the AMHP termed a 'goldfish bowl' and commented on how these working conditions felt stressful. How AMHPS work in situations that are immediately risky is explored later in the chapter but during this observation I noted that the AMHP presented as calm, paced, and methodical in her manner. In addition to the stress perceived by the workers, I reflected on how the individual, held in a place without their consent, potentially experiencing distressing thoughts, might feel seeing this group sat in the office with their files, books and ID badges.

The assessment took place in a side room, but it was still possible to hear noises from outside – or people shouting and a disturbance that happened to be occurring outside the hospital. The AMHP interviewed the person alongside two doctors:

> ***Participant B: Can you remember what the ward was like?***
>
> ***I know it's hard but please give it another go, to explain what's happened..***
>
> ***I'll try another tack – what happened when you were first unwell? Would you agree to stay in hospital for a few weeks? Maybe, you might want to leave.***
>
> ***We'll arrange an admission; we'll agree on that. How we go about it….***

My reflective memos note: *displaying empathy, you can get your clothes washed and red, get away from the noisy corridor'.*

The AMHP also kept the person informed, 'we're going for a chat and will come back to you soon'.

In terms of working through the information, her conversation with the doctor evidences the information she was considering:

> ***To doctors: It's the capacity, get him talking about anything just to assess capacity. Looking suspicious, thought blocking? Getting distracted by noise. Said he was unwell, in hospital but not why he's unwell. Said it was possible he may want to leave.***
>
> ***Participant B to me: Quite a different assessment but we found out what we needed to do fairly quickly'***

Has to be [Section] 2, not seen by services for X years and neither of you [the doctors know him. Make sure I don't confuse him with the other guy I've been trying to sort all day. So…I think Section 2, he needs a fresh assessment, there's not a treatment plan in place, he needs assessment for treatment plan. We don't know how accepting he'll be. Section less restrictive, he's agreeing to come in, Section 3 is heavy handed'

To me: I don't know whether I'm coming or going'

The AMHP later gives a rational to the parent of the individual :

'We are proposing to admit him to hospital under Section 2. He's agreeable but not sure he has the mental capacity to consent. I need to authorise the admission. Can only be voluntary if they really know they're going. More ethical to admit under section than admit without any rights. Do you know your rights [as Nearest Relative]'?

Reflective memo :a note on the environment long shift, man threatening, juggling, goldfish bowl, put myself in the corner, shouting'

This extract sheds light on decision making 'in action' and incorporates many of the analytic themes. This AMHP acknowledges that she is juggling lots of thoughts and trying to attribute the correct information to the correct person. My memo reported that she is typing her notes as she speaks, maintaining a record. There is direct reference to being 'ethical' and promoting rights, and that this is underpinning the decision to detain suggesting the use of **values and ethics** to situate decision making whilst also having explicit awareness of the **power** inherent in the role. In this situation the AMHP cites the MHA and the statutory grounds for when to use Section 2 – admission for assessment, and Section 3 -admission for treatment, and articulating with the assessing doctors and later the family member, her rationale for deciding upon Section 2. There is a reliance on the legal framework for decision making in terms of this specific decision. In terms of how the AMHP finds the 'space' to make decisions, her approach is to be methodical and take some control over the 'chaos' or **Managing Uncertainty**.

4.18 Conveyance:

Themes:

- Professional Identity: Professional Discretion
- Values and Ethics

Once the AMHP has made the decision to make an application for detention to hospital they are responsible for arranging transport or 'conveying' the individual to hospital.

In relation to the older woman assessed in the care home, Participant C talked through the logistics of how she would be transported to hospital:

> ***Participant C (Obs 6) to Participant A: Frail, elderly, psychotics powers…you want to put her in your car instead of an ambulance. You're going against Code of Practice so have to justify.***
>
> ***Participant A to C: I wouldn't consider it unless you've got someone from the care home sat in the back with her'***
>
> ***Participant C: I can't justify 999 ambulance; I could be waiting ages.***
>
> ***Participant A: She needs to be taken to hospital as quickly as possible due to renal failure (if one fib doesn't work you need another) you need to get back for your tea!***

This 'pearl' from the analysis illustrates **professional discretion** in practice. There is overt reference to the Code of Practice and what this states around transporting people to hospital. The AMHP displays empathy and discusses what 'feels' the right course of action in terms of the response to the age of the person and what they are experiencing. The colleague cautions against this but then offers a solution to speed up the ambulance 'if one fib doesn't work you need another'. This suggests the ways in which AMHPs use their skills to navigate the system in a way that brings about a desired outcome based upon the **values** that they bring to the role and situation. This evidences how the AMHP attempted to regain **power** or control over the situation. This extract also evidences the use of humour and camaraderie that these colleagues used to support each other emotionally with the task, the use of interpersonal skills. It also identifies something around how AMHPs perceptions of the person and the assessment based on characteristics or demographic information impact upon their approach.

This suggests that the AMHPs values and beliefs inform their decision making. This is explored further in the interview data.

4.19 Being Human: Human connections or 'making space'

The analysis identified a further distinct theme that links to a sense of duty and professional identity but is specifically related to what can be termed '**Being human'.** This theme does align with the interpersonal skills which are a sub theme of **Professional identity, in that it is an approach the AMHPs take to forming a rapport** with others. The defining characteristics of Being Human as identified within the data corpus was around how the AMHPs pause to 'make space' and find ways to sit and be present with the people they assess. During the observations all the AMHPS displayed ways in which they made attempts to connect with the person being assessed.

- Wording of the note – the AMHP who agonised over how best to convey information without causing unnecessary alarm.
- The AMHP in the care home helping out with a cardigan and using reassuring physical contact to help the person feel more comfortable.
- Practical help e.g.: ***PA: 'You can still go out for cigs'*** and saying that the person can get some clean clothes and have some food on the ward.

The exception was the police station in that the AMHP sat quietly and did not speak directly with the person. However, the observation of this AMHPs practice found that this connection was considered in other ways. For example, given the approach I had observed the AMHP to take during other assessments it appeared to be an intentional action to sit silently and make space for the officer who the person was responding to, to take the lead. The thread that runs throughout these examples can be related to dignity and respect – how the AMHP demonstrates this, and why they do this as this motivation sheds light on the values that the AMHP brings to their practice.

This is explored further in the interview data as some of the AMHPs spoke about learning the legal aspect of role almost as an actor learns lines, which then allows them to bring their own skills and values to the role. For example, it may not be a specific decision to be made, but is a conscious aspect of AMHP practice to help someone feel at ease, reduce power imbalance, demonstrate empathy and involve them in the assessment - this aligns with the Guiding

Principles and the interview data analysis explores when this is knowingly the case or is related more to the AMHP values being intrinsic in AMHP practice.

4.20 Summary of Chapter:

In summary, this chapter has outlined a 'day in the life of an AMHP' using the analogy of a journey to set out the unpredictable nature of the AMHPS working day. The observations all highlighted the uncertainty, logistical challenges, contextual pressures, and interpersonal skills that AMHP encounter and employ in their every day. The analysis also identified the reflexivity, synthesis of knowledge and professional discretion that underpins the AMHPs decision making. The extracts presented in this chapter sets out some of the pathways down which the AMHP journeys, and the about turns and barriers encountered during their duty day. There is a sense of the clock ticking and the AMHP attempting to gain control – or power-over the situation by pulling together the various elements required to set up and then attend the assessment.

The context within which decisions are made has been detailed as this helps to make sense of the ways in which practice deviates from statute and the Codes of Practice. For example, the Code of Practice provides guidance on how AMHPs should arrange conveyance or how they should determine which doctors would be most appropriate to involve. In practice resource constraints can be seen to limit the options and the analysis evidenced how AMHPS use professional discretion when carrying out the role and fulfilling statutory duties. The impact of place and emotion (such as anxiety) on decision making has been set out, and the ways in which AMHPS maintain a sense of control and power over their working circumstances. This includes the ways in which they utilise support and manage their resilience and wellbeing. The next section develops these themes based upon the interview data, exploring how AMHPS reflect upon what they do in terms of how they describe the role and the decisions make on a daily basis.

Chapter 5: How AMHPs talk about what they do and the decisions they make:

5.1 Introduction to the Chapter

This chapter explores the analysis of the interview data that used semi structured interviews to reflect with the AMHPs upon the work they carried out during the observations. There were additional interviews with AMHPS that were not observed, and which are also included in the analysis. The Methods Chapter explored if there were any differences in the data, in terms of 'performance' and I reflect on the ways in which the AMHPS who became familiar with me spending time with them, potentially spoke differently about the role.

Chapter 4 set the scene for AMHP decision making, providing the context of AMHP practice within this case study site, and introduced the analogy of a journey that the AMHP makes during their duty day. This chapter develops the key themes that were identified through analysis of the fieldwork data:

- Managing Uncertainty (AMHP wellbeing and resilience)
- Spaces and Places (Context and the impact of emotion on decision making)
- AMHP Motivation
- Professional Identity (Professional discretion, practice wisdom, knowledge, skills, and traits)
- Values and ethics: the lens through which decisions are made
- Power and Powerlessness
- Being Human – connections and making space

Each theme is considered in relation to the research questions, to relate back to what the research can contribute to an understanding of how AMHPs make decisions. The fieldwork data suggests that there is not a clear framework or process within which AMHPs make decisions. Rather the analysis of the first set of data identified that decisions are made through the lens of how practitioners perceive the AMHP role in terms of a statutory role that places duties and expectations upon them. The AMHP then uses a set of skills – interpersonal,

logistical and skills to manage uncertainty, which arise as a consequence of the context within which they operate. This section of the analysis can be considered to identify how AMHPs make sense of what they do in terms of the role, the challenges, their motivation. It also sheds light on how AMHPS talk about their role and how they make decisions.

5.2 Managing Uncertainty:

The observations shed light on the waiting or 'limbo' when, on a duty day the AMHP is unsure what the day will bring and what time the referral will be received.

> **AMHP C: All day you're in limbo (p17)**

In the interviews the AMHPs spoke of how they felt at the start of the day in terms of waiting for a potential assessment call to be made:

> **PD Interview: 'Different people have different perspectives. Personally, I much prefer having an assessment arranged as long as I've got a doctor and as long as I can go out, I've got my day planned. The worst thing is just sitting without an assessment and looking at your watch when it's approaching sort of four o'clock and thinking I can still get one through and have to arrange a....The uncertainty is definitely the worst part for me. The best thing you can hope for is for in the morning for it [the referral] to come through and have time to co-ordinate it'**

This AMHP also related uncertainty to his emotional wellbeing in terms of experiencing anxiety and that waiting for the unknown was more anxiety provoking than carrying out the assessment.

There was also discussion about the time of day the assessment could be arranged for and the impact of resources on timings. For example, the timing of the referral may have a knock-on effect in terms of the number of doctors who may be available, resulting in the AMHP making a compromise in terms of who accompanies them on the assessment. This choice can then have an impact on the outcome of the assessment as the accompanying decision makers may take a different stance on the action that needs to be taken. The later the assessment is in the day the available resources may also be limited such as availability of a bed, or an ambulance for conveyance.

> ***Interview PD: Yeah so the problem seems to be that you go through the list and a lot***

of people [doctors], there seems to be more of a push within their work places for them not to go out, for them not to go out during the day, during clinic et cetera. So generally, you'll get people saying you know I can come out, but I can only come out at half four, five o'clock which means you're already on the back foot. You've already, sort of…you've got a full day at work and then you're having to do the assessments sort of last thing in the day.

AMHP E: You get used to being on AMHP duty, but that doesn't mean to say it's not anxiety provoking, even after doing nearly twenty years I still think oh goodness, I'm on duty today. The phone rings and you think God knows what I'll be doing later , where I'll be, what time I'll get home. That sort of thing' (p17)

This timing then had an impact on the resilience of the AMHP – for example in terms of fatigue and the 'ambient' stress of the impact on their personal life, if they are required to work beyond their usual contracted hours. The location of the assessment also became apparent as a factor in the AMHPs stress levels. AMHP C spoke of being '**knackered by three o'clock'** and identified that challenge of needing to '**be fresh coming onto the assessment to make all these complex decisions and all of these plans'.**

The analysis identified that the AMHPs took steps to regain control over the uncertainty of what their working day may bring. These varied from practical arrangements they could put in place such as getting a good night's sleep the night before being on duty, booking in flexi time to recoup the overtime worked. Experience and confidence in the role also had an impact on the approach one AMHP took to managing the uncertainty as regards the impact on his anxiety levels:

PDInterview: Yeah, I think, it's like anything isn't it. I think the more situations you've been in and the more experience you have, the easier it is to picture what you can do in those given situations. To start with you're thinking 'what if this happens', 'what if I can't get an ambulance', and you know you never gonna sort that until the next morning. There's always an answer. Sometimes you are stuck, and you know you have to hand over responsibility but there's an answer there and so that kind of alleviates some of that anxiety, thinking, knowing what the alternatives are, helps.

AMHP C spoke about feeling anxious about situations she had not been in before as until she has gained this experience, she would dwell upon it and worry that 'today might be the day'. For example:

> ***I'm very much the kind of person that once I've done something I'm fine. But I can worry about doing it. So, for a long time I didn't have to go and get a warrant [from a magistrate for the police to enter a property] and that really fazed me. But it won't now 'cos I know what I'm doing' (p10).***

AMHP H shared a similar view:

> ***I used to really fear community assessments and I think it's a psychological thing as well because you're waiting for the phone to ring, you're on duty and you're waiting for the phone to ring and when you're a bit nervous going out into practice, I think that worries you a little bit' (p21)***

The analysis identified that experience and 'learning the ropes' was key to reducing some anxiety associated with the role, but across the AMHPs an element of anxiety remained in terms of dealing with the unknown or **managing uncertainty**.

The analysis also identified the potential impact of uncertainty on the experience for the individual being assessed:

> ***AMHP B: 'I am a bit of a one thing at a time and I've got a bit of a one thing at a time kind of brain. So that is a bit of a struggle yeah, I've got to be careful that, you know, everybody gets a good service really, there's a risk to be sort of overlooked, neglected, slip through the net in whatever way' (p11)***

This is of relevance to decision making as identifies something around setting the scene for effective decision making or finding that space to make decisions.

5.3 Spaces and Places:

The theme of the impact of place was evident across both data sets – the observational data and interviews. Place had an impact on uncertainty and an impact on the emotional response

of the AMHP to the situation in terms of their physical safety and their perception of the availability of emotional support. Place also had relevance in terms of the power dynamic between the person being assessed and the AMHP, the implications of meeting with the person in their own home or a public place.

Community assessments were associated with uncertainty with concern about bed availability a background issue, although usually the AMHP had addressed this prior to 'going out' on the assessment. Logistical concerns were prevalent with concerns about how long a wait there might be for an ambulance, or if the police would support if necessary.

All the AMHPs spoke about times when they had felt unsafe or put at risk – physically or emotionally. One AMHP described receiving a community referral as '*heart sinking*'. (PGp37)

In the context of whether she planned to continue in the AMHP role she was clear in her view regarding work 'in the community' (usually an individual's home address);

> ***AMHP Participant G: 'I just can't be bothered with it all, the hassle. I don't mind doing the assessments, and I don't mind doing the paperwork, I don't mind anything of it. I just don't want to go out into the community, because of the police and ambulance problem. And it's risky, I'm not getting any younger, and there is a risk involved. I prefer to do it in safer environments'*** (p36)

This AMHP recalled having been chased out of a house by a person wielding a hammer, and spoke of a challenging situation in the community:

> ***AMHP G :And I don't know, people get carried away by, oh well that's our duty, and that's this, that and the other. And I did do something once, and I stayed outside somebody's house hours on end, waiting for the ambulance to arrive that didn't arrive. And I cried and cried and cried 'cause I felt so alone. And I thought, do you know what, I wouldn't do that again! I just wouldn't do it again. Why would I sit in the middle of a really rough part of the City, because the ambulance won't come? I'm leaving. I wouldn't do it anymore, and the manager had switched their phone off by mistake and I couldn't get through to anybody. It was awful. And I just thought you know, what am I doing here? So, I think people do put themselves in***

> ***very risk situations, Oh well, we can't leave them because this…well no. no, no. I've got my family; I've got my life. I'm not risking my life for this. No way'*** (p38)

This extract clearly evidences for this AMHP how 'place' had a significant impact on their emotional wellbeing but also demonstrates the limits, for this AMHP of their '**sense of duty'**. This is not at all costs and suggests that for this participant the experience of being in uncomfortable and risky situations led her to put in place boundaries as to when 'enough is enough'. This can be viewed as the AMHP using the **interpersonal skills** associated with assertiveness and using practice wisdom to influence decision making.

The observations suggested a 'hierarchy' in terms of which type of assessment the AMHPs preferred. Here one participant describes a hospital assessment as 'a lot easier' as there are less decisions and factors to manage:

> ***AMHP E: It was one of those lovely ones where necessarily there, there's no complicating factors like there are at home, conveyance, bed location that kind of thing. They're already in hospital so that makes it a lot easier (p10)***

AMHP A made a similar comment:

> ***AMHP A: It often feels, particularly going out in the community and you just don't know how it's going to work out, hospital assessments feel a lot more under control so to speak. You know, in terms of variables, there are far fewer of those. In the community all sorts of things can and do happen (p7)***

AMHP D spoke about the thoughts he has 'in bed' at the end of a working day and that community assessments tend to be those that he dwells upon more in terms of his decision making due to the unpredictable nature of them:

> ***In the community, everything's so unpredictable and fluid, it's easy to put a foot wrong, especially when people are displaying unpredictable behaviour and it's the first time you've me them' (p9).***

AMHP H highlighted a sense of isolation;

> ***You're in the community by yourself, the doctors often will go and then you're left with a duty manage who, you know, kind of, help out and answer the phone but it's very much you feel isolated…after five [pm], physically there is no one [to call on for support] (p17)***

Another AMHP highlighted the impact of a delay with an ambulance arriving on his wellbeing:

> ***AMHP E: It's extremely stress provoking. You're sat in somebody's house with them for three or four hours, seems like an eternity. People can be very unwell so that's tricky. Obviously AMHPS are only human. Get quite tired after 5 o'clock, because you've done eight hours work haven't you, so that's a bit challenging to do that' (p12)***

Whilst the observational data identified the impact of place on the AMHP, the interview data shed more light on how place impacts on the individual being assessed. Some of the AMHPs highlighted this as a decision they make – how to set the scene to assess somebody in a 'suitable manner'. This seems to demonstrate where the AMHPs values influence their approach to practice. This was identified within the observational data as '**Being Human'**, making connections with the individuals being assessed, and which can be considered to occur in a broad range of ways:

> ***AMHP E: It's a challenge really. You try and do it in a 'suitable manner [as per the MHA] You interview people in all sorts of situations sometimes, which is not ideal, but you do the best you can. Interviewing people in corridors or standing up, music on, that sort of stuff, so it can be quite hard (P14).***

This extract suggests that the decision was underpinned by adherence to the MHA Code of Practice but that it was also about applying discretion in terms of what a 'suitable manner' is. The AMHP referencing some of the obstacles that it is not possible to plan for in advance of the assessment. The analysis identified some of the decisions the AMHPs took to mitigate the adverse impact of environmental factors during the assessment. For example, AMHP B

used a separate room on the ward during one observation and reflected on this decision during the interview:

> ***AMHP B: 'Yeah, and trying to reduce…you know, trying to care for people who are around other people who are really agitated. Like obviously, it was distressing him all the kerfuffle going on outside. I mean, in terms of things that went well [during the assessment], I think obviously the decision to take him somewhere else to assess him was a good one. And just the fact that he was in here with some very noisy and disturbed people was obviously a big negative in the whole thing' (p31)***

AMHP A referred to '**little dark dingy rooms that are horrible'** on the ward and made attempts to avoid these, referring to the environment that someone is in as important in setting the scene for the assessment in terms of the planning that takes place before the interview. Another example involved decision making around who should be present at the assessment, collaborating with family members to make a decision as to whether they should be present to support the person:

> ***AMHP C: So I can ring someone up and speak to the Nearest Relative and suggest do they want to come along and they say, well actually it's going to make things far worse sort of things worse for me, or yes it would be useful. So, these are things you need to check out and kind of get the atmosphere in that environment, so interpersonal environment right.***

AMHP A outlined his approach to assessment, in terms of making someone feel comfortable:

> ***AMHP A: And you know, it's like first base Social Work isn't it, communicating, engaging it used to be. I don't know what it is these days, key skills rather than competencies, but that ability to respond as one human being to another. Because that's your baseline isn't it, it's like two human beings in a room, this is what we're doing. I've got one role and you've got another role but there is that thread of humanity connects us. And it's that that I try and maintain come what may because***

if you lose that then I think it can become – abusive is too strong a term but is kind of oppressive. Because you can say all the right things, do all the right things but nevertheless you can end up sailing towards something that has got an emotional feeling that is quite oppressive' (p14)

These findings support the theme of **power and powerlessness** that underpins how AMHPs set the scene for decision making. It sheds light on how they recognise and take steps to mitigate the negative impact of the decisions inherent in the role in terms of the power to detain. It also develops the theme of **Being Human**, the ways in which AMHPs bring their interpersonal skills to the role to make space to be with the person being assessed. One of the AMHPs explicitly linked the MHA Guiding Principles to setting the scene for the assessment, in term of maintaining dignity and respect:

AMHP H 'I've had many assessments where they've been in A & E, there's only a curtain separating people, it's not ideal, there's members of the public running around. It's about- it sounds like a small thing but just saying can we assess in a private room and being mindful in terms of confidentiality and what the dignified thing for the service user. We have to be mindful. I think the [Guiding] principles are very much part of my decision making and very much part of my Mental Health Act assessments' (p28)

Participant A also spoke of this sense of duty to time the assessment appropriately and referred to the AMHPs role in making this decision, based on a value base:

The other thing is to do with time, you know, it's often not ideal to be assessing someone in the middle of the night. If someone's come after a stressful day and they arrive at midnight or 11 o'clock, is it really ethical to wake them up at 3 or 4 in the morning for an assessment, or should they be left to sleep 'til at least 6 o'clock. So, there's that consideration as well, but I think that's probably more if an AMHP thing than a doctor, I think that's something we probably feel more strongly about, or conscious of' (p18)

This extract also relates to the impact of resources on the assessment, for example delays in finding a doctor to assess, and the AMHP mitigating the impact of these resource pressures on the experience of the individual. It also ties into the theme of professional identity and interpersonal relationships in terms of perceptions of the other workers involved in MHA work. This AMHP then goes on to talk about the ways in which as an AMHP workforce they are using the statute to provide a rationale for why they advocate for delaying assessments at times:

> ***AMHP B: We as AMHPs feel really strongly that somebody…it's only fair to give someone..to assess someone when they're presenting in a sort of representative way you know. There's a big risk if you assess them when they're heavily under the influence, you'll make the wrong decision and you know, somebody could be deprived of their liberty when it's not really warranted' (p19)***

Underpinning these types of decisions appears to be consideration by the AMHP of the impact of the setting, timing, and other environmental factors on the opportunities to involve the person in their assessment. Setting the scene appropriately to build rapport and reduce the power imbalance inherent during a Mental Health Act assessment.

One AMHP spoke specifically about how she met with an individual out on the street, outside her home. Place is relevant here for the AMHP – they were in a public space and the AMHP acknowledges some degree of risk but also how the location impacted on the dynamics between her and the person being assessed:

> ***AMHP G:'I think what went well about it, was that, I mean sometimes I maybe put myself slightly at risk, but because she refused to speak to the doctor, I sort of followed her, and it was out on the street, and I just said to her, I just kind of tried to speak to her at her level, and leaned over a recycling bin, and said, just please talk to me. Let me chat to you, I just want to talk to you'***
>
> ***'So I managed to engage her, not for long, but I think if I hadn't done that, I wouldn't have been able to make that decision, because I was able to make a very quick assessment of her mental state in those five, six, seven minutes that she gave me. And so I felt pleased that she had responded to my, whatever, communication skills***

you know? And I didn't frighten her, and that she would speak to me, and that she was in control. When she said it was over, it was over. She was able to manage it' (p24)

Place seems to have an impact on decision making in that some of the power shifts given assessment can occur in a public space, or in an individual's own home.

5.4 Professional Identity – professional discretion and practice wisdom and the impact of emotion on decision making

The analysis identified the ways in which AMHPs take steps to **manage uncertainty** and the challenging contexts within which they operate. The interview data shed light on some of the nuances of how AMHPs recognise barriers and what they do to reduce the impact on their decision making.

For example, AMHP A makes reference to the pressure of time impacting on how much information it is possible to gather prior to going out to carry out the assessment and that he attempts to fill in gaps in the knowledge by speaking directly to people. In reference to the use of tacit knowledge, or intuition he stated:

AMHP A 'I think in terms of intuition, the I suppose, using information that I get through intuition it's almost I have to..I think the accuracy of that tends to go up within the least rattled or agitated I feel internally. So if I feel, you know, relatively at ease with something, or not, I don't know, able to access that sort of information, then I can be more confident that it's going to be accurate, whereas if things are going at 100 miles an hour, there is sometimes a gut response, but I'm not sure of that, if that makes sense' (p17)

During the interview we spoke about the note he spent time drafting outside the home of the person he had attempted to visit during one observation. When reflecting on the note he wrote and the time it took he stated:

> ***AMHP A If I feel rattled I'm aware of the impact that has on my reasoning, so I'm able to just..what that means is it maybe takes a bit longer to think things through or I will double track and just think, have I got this right, like with the letter I wrote to…I wasn't feeling rattled as such it was more a case of I knew I had to get it done and I was like, let me check is this right. And it's more a case of that I think when I feel rattled just having to double check, think it through again, bounce an idea off someone' P18***

He went on to talk about how if there is no space to stop and think then decisions are made on a reactive basis which he describes as:

> ***'Potentially dangerous practice. Because if you are reacting then there is no – it's almost like bang bang bang, I don't know, something happens and then you react, something…there isn't the space to step back from what's happening and see the bigger picture. And if you don't see the bigger picture then I think often you react rather than responding. If that makes sense?p18***

This links in with the theme of professional wisdom, or tacit knowledge, 'gut instinct' that AMHPs perhaps employ when in situations of heightened emotion. For example, using this knowledge to assess a situation, particularly around the risk to personal safety as was outlined earlier. In this context the AMHP seems to be suggesting that tacit knowledge if not as reliable as analytic knowledge to inform decision making.

AMHP B also reflected in the impact of heightened emotion on decision making, as a consequence of a lack of breaks and feeling hungry :

> ***I mean yesterday I had my lunch at about quarter past 5. Today I managed it at 2 0'clock which was good. But yeah, busy days, I don't think you make your best decisions when you're frazzled and being pulled in loads of different directions. I mean, when I'm saying about decisions, I don't mean the final outcome in the system, I mean the smaller decisions and the planning and the deciding what to do and do when. I don't feel that there's any overall outcomes that have suffered' (p20)***

AMHP E reflected on the impact of tiredness on decision making:

> ***You're making quite weighty decisions and you think is my mind in the right place to make this decision because I might have done nine/ten hours already. The process, just the sheer effort in setting up, does make you feel quite tired. And yeah, it's almost like…I don't know, it's hard to say really in terms of how mentally alert I am at that particular time. (p20)***

Again, this reflected how AMHPs recognise the pressures of the role and take steps to mitigate the impact of this on their wellbeing. The findings identify how AMHPs then make the link between their emotional state and their perception of their decision making. The AMHPs reflect on how if they manage their emotional and physical wellbeing this then sets the scene for them to feel more able to make 'good' decisions. Coping mechanisms included one AMHP ensuring they slept well the night before, mentally preparing for a long day ahead. One spoke of how he brought food and money to work and made sure his phone was charged and another practised a mindfulness exercise at the start of every working day.

Another AMHP (Participant F) reflected on the impact of all the other decisions made during a duty day in terms of distracting him from the decision regarding use of the Mental Health Act, making an explicit distinction between the 'key' decision in terms of whether or not to apply for detention, and the myriad of other decisions the AMHP is accountable for:

> ***AMHP F 'Process, sort of process logistical stuff can be the…sometimes I perhaps forget about the assessment and the importance of the assessment ultimately. It's not that it gets marginalised, it's just the process and just the sheer effort involved, coordinating, arranging, that is huge' (p14)***

Some of the AMHPs spoke about how their non AMHP role's placed additional pressure on them as alongside the consequences of the duty day they had the background stress of the caseload they held and the knock on effect of not being available to respond to issues with other people they supported, due to being on AMHP duty. One AMHP described the impact on decision making as a consequence of these competing pressures:

> ***AMHP H: I think if you're in a state of mind where you're feeling overwhelmed, I think it can affect your decision making, you know, if you're not relaxed it can affect how much you can think about things, do you know, in terms of the smaller details***

> ***of assessments. I think in the back of your mind if you're thinking, well I've got someone as a safeguarding referral, I need to do this…I don't think you can give your all mentally to that Mental Health Act assessment, I think it impacts on your ability to do that I do' (p19)***

One way in which the AMHPs mitigated this risk was to request time with management to catch up on work or write reports, but the data suggests that the receptiveness of some team managers varied dependent upon how familiar they were with the AMHP role. The AMHPs also spoke about how peer support enabled them to feel some of the pressures associated with the role were reduced, along with the opportunity to use supervision to reflect on their practice. However, across all the AMHP participants, a lack of availability for AMHP specific supervision was cited as an issue.

> ***AMHP H: I've never had AMHP supervision in four years, I've never had AMHP supervision once' (p32)***

AMHP A reflected on the AMHP role in relation to the 'every day' Social Work role:

> ***So it's no different doing AMHP stuff to having to deal with the normal parade of human risk very often that you get in general Social Work. People who are in quite awful situations or experiencing quite distressing illnesses. So I suppose the difference between that half hour [MHA assessment] sometimes is there can be…the intensity can be ratcheted up compared to regular case work. That's what the difference would be. But in terms of my mental wellbeing for myself would be just the same stuff that I do when I'm dealing with case work I guess (daily meditation) (p9)***

These parallels made between AMHP practice and Social Work practice in general suggest that those AMHPS who hold two roles also have the additional burden of 'juggling' tasks and thus develop ways to best manage this. The analysis suggests that practitioners use discretion to decide what tasks are important and what can be left undone - and being comfortable with that sense of always having tasks that should be done or aren't fully completed 'by the book'. AMHP A: **'So how I deal with it is there is a whole lot of stuff that doesn't get**

done'. However, the extent to how easily this sits appeared to vary between AMHPS with some of the participating AMHPS identifying this as a key stressor. For example, outstanding tasks that are sat waiting remain in the background as a mental workload which then impacts upon stress levels on AMHP duty days. This was cited by some of the AMHPs as a factor that led them to consider stepping down from the AMHP role.

In terms of organisational pressures impacting on AMHP wellbeing and resilience, one AMHP spoke of the difference when working in a 'crisis team' where all team members were responsible for responding to mental health crises on a daily basis, not always within the legal framework of a Mental Health Act assessment. The analysis identified how feeling a sense of belonging in a team that had a shared understanding of the impact of this type of work, on stress levels but also the logistical challenges, led to her feeling more supported and able to rely on colleagues to help out:

> ***AMHP B: Which is great because I think I've sort if got used to, as an AMHP, you feel that you are really on your own with stuff…..yeah and just things like practical stuff. Like I was detaining somebody, I hadn't managed to reach the person that I thought was Nearest Relative and there was concerns about the home situation. So I was going to go out as early in the morning as I thought was polite, which was probably about 7.15am. But I said to the shift coordinator, 'Is there someone I could borrow so they just found a volunteer and I took a nurse with me' (p22).***

This relates to how AMHPS **manage the uncertainties** or stresses of the role (in this example the risk to personal safety due to the unpredictable home situation), enabling clearer focus on fulfilling the role. Or in other terms, being less 'rattled'. This supports the AMHP to set the scene for more effective decision making.

AMHP E spoke about resilience and how experience within the role had led her to become firm about taking time back when she had worked late;

> ***AMHP E: 'So I'd rather leave at 6 [pm], so I can go home and be with my kids, rather than stay to 9 o'clock on a Friday night. And I do that because I really look after myself. I always take my time back, I always have lunch, I always take a break. I***

will never burn out. I've been doing this job for 25 years. And I wouldn't stay late and not take the time back because who is going to benefit from that?'

This extract suggests that the AMHP makes a direct correlation between her wellbeing and her ability to fulfil the role. This recognition of the impact of emotion on decision making was also identified by AMHP C although this extract introduces the idea of character traits setting the scene to become an effective AMHP, implying that at the outset it is necessary to approach stressful situations in a particular way:

AMHP C: I think you need to be a certain kind of person to be able to do the AMHP role. So I think you've got to be quite level headed and not panic and not get really anxious so that you can go into the situation, you can assess it and you can keep a calm head. Because if you're quite anxious and worry about absolutely everything then it would just make the situation worse' (p14)

When considering the fieldwork data and interview data it is of note that AMHP B in particular utilised peer support to talk through challenges and appeared to find the situation challenging when setting up the assessment. Once in the assessment setting, she presented as calm. The analysis identified this shift in AMHPs which can be considered in terms of 'performing' the role and is related to place and space. For example, in the safety of the office environment with peer support the AMHP can offload and share anxieties with, but is then able to step into 'role' as the AMHP when liaising with others and carrying out the interview part of the assessment. There appears to be a formality about the role which perhaps reflects the statutory powers and respect that AMHPs hold for the role.

5.5 Place – the impact of location and context on decision making

Whilst the data identified that the potential location of the assessment can lead to anticipatory anxiety for the AMHP in terms of the less predictable nature of some settings, the interview data also shed light on the impact on the AMHP whilst actually within the setting. The AMHP is required to reflect in action in all situations as they synthesise information to make decisions, but the analysis identified that some 'places' make this a more challenging task. AMHP B articulated this as:

> ***'It makes it really difficult to focus. I mean yesterday it was terribly difficult to focus on what I needed to do, especially if you've got people who are a little manic or agitated in whatever way and they'll keep coming in the office and won't be able to grasp that they need to not keep coming into the office. Yeah that's a problem with it being a bit of a goldfish bowl in here. If people are angry and agitated obviously that's even worse (p13)'***

When, during the interview I put it to AMHP A that making 'space' in the midst of an assessment enables thinking time, or reflection on the situation he disagreed:

> ***'It's also just there is no thought there as well. I meant it's the ability to actually sit with someone and not necessarily thinking at all, your just actually being present with them and seeing what comes out of that presence. So thinking isn't always the way into these things. Whereas being present with somebody what's appropriate can come out of that presence'. (p19)***

He described the assessing doctor as being 'present' in the assessment too, which articulated what he meant by this term:

> ***'There was a kind of sense that the Doctor was really there with him and some of the doctors you can feel it's almost like, oh this gentleman is exhibiting these symptoms and all the rest of it, and it's almost like that intellectual knowledge in some way separates us, it's almost like they are there on that intellectual, that sort of level of looking at somebody and collecting data and then analysing it but they are not really with them in any human sense, where I think with the Doctor there was a warmth to him which was kind of we are here together on this one. A sense of us, and that's what I try and develop on assessments (p19)***

When I asked about how being present is developed as a skill his view was that it is not something that can be taught or that necessarily comes with experience as a practitioner. He gave the example of a newly qualified Social Worker who may find being present with someone comes more easily than someone who has been qualified many years:

> ***'You could end up burnt out and really being a million miles from being present with somebody'***

So, for this AMHP decision making comes from making the space to be with a person and to step back and 'see the bigger picture' to ensure that decisions are based on this as much as possible. This sits within the sub theme of practice wisdom but challenges the assumption that practice wisdom necessarily develops with experience which the other AMHPs focussed on as aiding their effective decision making.

5.6 Place as a space to reflect

Whilst place appears to have an impact on the resilience and opportunities for the AMHP to focus and reflect on decision making whilst carrying out the assessment, the analysis also identified how space is used to reflect before and after the assessment. For example, the observational data highlighted the use of the car as an informal space to plan for the day ahead and think through tasks. Some of the AMHPS also spoke about the use of space to transition from their AMHP duty to ending their working day, specifically the use of their car. Returning home after an assessment marks the end of the AMHP duty journey and a boundary to delineate from one role to the next:

> ***AMHP H: I think when I get into the car, it's a technique I've used from when I was training to be a social worker, I think right, that's it now, I can think about it in the car, when I get home I that that psychological cut off point. I'll have the journey from base to my home to be the time where I'm thinking and unpicking and once I get home I think right that's it now, I'm not going to think about it and I think that's how I learnt to do it, to have that thinking space on my journey home' (p30).***

Participant A described how he would park his car up and walk the last stage of his journey home to unwind and reflect on the day's events to enable him to then 'switch off' from the pressures of the day:

> ***AMHP A: 'If I don't drive my car – if the assessment is late then I would go home, but 99 times out of 100 I will park the car up and walk the last 30 minutes home, because I get to walk along the river' (p9)***

However, another AMHP referred to his home environment and the end of the day as a place to reflect, an extract that also highlights the ways in which the role can be a burden in terms of findings ways to make sense of and reconcile the day's events:

> ***AMHP D: 'You have to sit in bed at the end of the day and think about it and think well could I have done that better? Was there a better way of doing that? Under that pressure and in those situations there's probably always going to be something you'd do different (p19)***

This was an exception to the views shared by the other AMHPs, who tended to identify the ways in which they did not take work home with them.

5.7 Practice wisdom and the impact on decision making

The analysis of the interview data identified how all of the AMHPs consider the journey their practice has taken since qualifying and taking on the AMHP role. This was referenced in terms of how they feel about the different types of assessment whilst waiting for the referral to be received. The theme can be developed to explore how experience, which for the purposes of the analysis is considered as practice wisdom as the data suggests this incorporates a wide range of skills, values and knowledge that is then applied to the role. Two analogies were used to describe the role – one as an actor learning lines and the other as a newly qualified driver hitting the road for the first time without an instructor alongside.

> ***AMHP A: You did ask a bit about experience. I think there is an element to which..'cause if you are trying to do that then part of the scenario is you are playing a particular role and you have to try and play that as well as you can do, so it's about the balance, well not balance it' s having both things isn't it, the human connection but you're the patient, I'm the AMHP, here's the doctor, we have all got out roles we playing like in a play or something like that. And if, I don't know, you are in a play on stage and all of a sudden you do something random you shouldn't have done, it throws everyone else out. So it's the same I think, and the more experience I have***

of being an AMHP the more you know what the role is so you know what the part..it's a bit like somebody playing Hamlet a million times or something, you know what it is and you can maybe sort of, I don't know, embody the role that little bit more because you don't have to be worrying you might fluff your lines because you know them so well if you know what I mean' (p21).

AMHP H: When I first qualified, it's really scary, it is. It felt a little bit like doing my driving test, I had someone who was with me all the time, an AMHP and then you go on to the rota, once you're warranted and then you're on your own. (p21)

Another AMHP reflected on her aspirations for the role and the realities of practice but also highlighted how for her the role went beyond learning statute and policy and was driven by values and a sense of social change. This extract illuminates how she defined this:

PG 'I learnt from one of my older colleagues. When I first started, when you're all new and excited and think you can change the world, before you grow up and realise that's a bunch of shit. I decided what I wanted to do, and it's the job that I've just got, which I'm not necessarily keen on doing right now, but there we go. So I moved myself, so I could learn what I needed to know, to do what I expected to do in ten years' time, and people thought I was being a bit strange, that actually I was going to wait ten years to do the job that I actually wanted to do. But watching the people that did the job, they were calm, and I wasn't. They were clear about what they were doing, and I wasn't. They had a different way of communicating with people that I hadn't got, and they took a lot longer than I did. So I went, and I learnt how to do that. And I watched one of the guys after having kicked a woman's door in with the police. And he stood at the side of this lady, who was creeping up the walls, psychotic right, and he just stood there, and she said that there were things in her sink, and he said 'show me? Just tell me about the things that you see in the sink, and be inside her world just for that minute, 'cause then you can understand how frightened she is and everything, and then you can understand what you need to do, to make her world different, and how you can get her safely from there to there, without making it any worse' (p39)

AMHP D spoke about how he reminds himself to slow down and make space for decision making as in some circumstances the need to carry out the assessment is driven by taking the first opportunity when an assessing doctor and bed availability align:

> ***'You have to be really spur of the moment…I don't think that's necessarily the best approach because you don't want to miss anything but I get my doctor, I go there, I do my assessment and that's dzz dzzz, but legally well no that doesn't have to be the case. I can go with the doctor, they can do the medical recommendation but then I sort of halt it there, go back, you know to find a quiet place on the ward, ring family, ring professionals involved. I'll try and break it up a bit just to try and make it a better assessment and try not to think of that as the be all and end all that now we need to complete the paperwork, because you do have time to put things together' (p8).***

The analysis identified that the AMHPs make use of tacit knowledge when carrying out the role, described as one AMHP as 'gut instinct' and another in a more physical sense when talking about assessing risk to self in the context of the role:

> ***AMHP H: 'The thing that you can't bottle is the hairs on the back of your neck, and you'll know exactly what I'm on about. When you walk into a situation and they just go (gesticulates to back of the neck) and you don't know what it is but you know there's something wrong, and you don't know why you need to keep away from this person, but you really need to be at arm's length'*** *(p42)*

The AMHPs also spoke about how they use risk assessments to inform their decision making – for example a model of understanding risk that makes some assumptions around past behaviour predicting future behaviour. Whilst this may demonstrate the use of analytic knowledge as this approach uses the application of a model of risk assessment, the ways in which the AMHP describes her approach suggests that subjective or tacit knowledge is also in use:

> ***AMHP B 'I mean, in terms of self-harming, sort of what would appear to be suicide attempts, it's a case of sort of looking for clues really. Like some people seem to make quite a few attempts but they always in some way ensure that they're going to be rescued, we know that they sometimes do things but they will always let***

> ***somebody know either what they're going to do, or what they've done. So, you know, that s big protective factor. So, where people will do stuff and it really does appear to be complete good luck they were found, then we'll obviously look much, much more, maybe more risk averse in our plan for them' (p17)***

The analysis also identified some recognition that there is a bias towards the view that there are more people being detained out of area and this might be fuelled by factors other than personal experience. This extract was of significance as the only data that elicited a more critical view in terms of how the AMHP was making sense of the context within which they operated:

> ***AMHP B: 'I think it's hard to say isn't it because how much of its just your expectation based on what you hear from other people, what you hear on the news. But I feel I've become more aware of people being sent out of area recently' (p24)***

This articulates something around the way in which this AMHP understood the impact of a dominant narrative on her practice. This concept of conscious and unconscious bias is explored further in relation to the Key Informant Interview and the ways in which the AMHPS spoke about the factors that underpin their decision making in terms of how they synthesis information about risk and use of the Mental Health Act to deprive individuals of their liberty. This section also explores how the analysis of the data shed light on how underpinning models or frameworks of understanding, in other terms, the AMHPS ontological and epistemological position, impacts on their approach to decision making.

5.8 Policy to practice: Values and Ethics and Professional Discretion

The MHA Code of Practice outlines the five Guiding Principles that should be considered when making decisions about a person's care, support, and treatment under the Mental Health Act.

The five overarching principles are:

- ***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.

- ***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.

- ***Respect and dignity***

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

- ***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.

- ***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 (MHA, Code of Practice, 2005, p23)

The interview questions specifically asked AMHPS how they applied these principles to their work.

The analysis identified a close relationship between AMHP practice and the statutory framework in terms of a rationale for decision making and as a tool to assert role and knowledge when working alongside other professionals. For example, a familiarity with the MHA and Code of Practice to justify decisions. For example;

> ***AMHP B 'I think I would always fall back on the Code of Practice, or you know Jones [Mental Health Act Manual] because that was, I mean it's in there that, sort of explained when Section 2 or Section 3 is appropriate. So I think, yeah, I'm probably not good at voicing my own opinions, so I'll always fall back on the, well the Code of Practice, yeah I'll refer to something in writing whether it's you know written guidelines, the Reference Guide of the Code of Practice (p23)***

However, threaded throughout both sets of data was how AMHPs 'fill in the gaps' between the statute and practice. This part of the analysis also included an exploration of the ways in which the Guiding Principles are implicitly and explicitly applied to AMHP practice. This then leads into how this value base and professional discretion is applied specifically to the concept of power and powerlessness. Use of the Code of Practice is also closely linked to practice wisdom in terms of learning the theory and then applying this to practice:

> ***AMHP H: There's the shift isn't there, because you do the legal stuff but the bit you need to learn is how to apply that to your practice and you can't do that until you go out and do that on an assessment yourself. You can learn the theory behind it but in terms of how it applies, that's the bit you learn when you're out doing it' (p23)***

AMHP B referred to the Guiding Principles as implicit in her decision making, and the impact of experience on how she applies these to the decision making:

> ***I think when you've been AMHP'ing a while, you always have them [the Guiding Principles] in the back of your head and it might not be very explicit. Like for example, I'm aware with Bob we didn't really discuss the least restrictive options but I think that was because it was obvious to us all that…you know, it almost didn't need saying that he couldn't be safely managed at home because he was so unwell. And in terms of, you know, I mean sort of clear about what the purpose of admission was, and that he needed assessing and be treated obviously as soon as possible and in quite an intensive way. So there was no less restrictive option. And I think, you know, involving him in terms of participation, involving him as much as possible in the assessment and listening to his views. So I think it's sort of automatic rather than…(p15)***

AMHP H gave a similar example of how she applies the least restrictive principle when making decisions:

> ***AMHP H: I think I always have them in my mind, the Guiding Principles. I think its…I can out them in hierarchy of importance but for me the least restrictive principle Is always at the forefront of my mind. I start with, well I work from the bottom up; can this person not be managed in the community or can they, then can they be managed intensively in the community is the next step. If not, then can they go informally, have they got capacity to consent to that, are they agreeable to that and if not then we're looking at use of the Act and I start from the bottom and work my way up' (p27)***

Another AMHP was less sure about how he applied them and demonstrated a will to underpin his decisions with the Guiding Principles:

> ***AMHP F: I hope it underpins what I do. I suppose conscious things like the least restrictive principle, and I hope it underpins what I do. Ultimately detention under the Act is one of the last resorts…I look for evidence that people have tried things..it shouldn't just be, please this person needs detaining so we just go and enforce it' (p15)***

The AMHPs spoke mainly about the Least Restrictive Principle when asked directly about use of the Guiding Principles suggesting from this small cohort of participants this was the principle that came most readily to mind evidencing how they underpin their practice.

Whilst the AMHPs did not explicitly link this approach to the Guiding Principles there was a constant theme across all the interviews in relation to how the AMHPs set the scene to develop rapport and respect the people they assessed. This sits within the 'respect and dignity' Guiding Principle. For example, the AMHPs spoke about how they approached their work from a particular stance:

> ***AMHP C: I think I'm down to earth, is probably what it is and I'm very honest with people and I'll tell people…explain what's happening, what's going on, introduce myself, make sure I'm very clear about what's happening. And that's important. But I think its that human element that we were talking about before. I think it is just acknowledging that this is a difficult situation, its challenging, and being empathetic' (p9)***

There was some evidence of professional discretion in terms of use of the law. For example, whilst reflecting on events during an observation, AMHP A described one police officer's creative use of statute as:

> ***AMHP A 'A triumph of common sense over bureaucracy' (p27)***

The AMHP explained that due to the concerns about the person being assessed he felt that this was proportionate to the risk present. It is of note that this AMHP had spoken about his 'anti psychiatry' stance and critique of the mental health system. This suggests that AMHP practice is nuanced and practitioners are comfortable at times with working more closely 'to the edge of the law', arguably taking a more pragmatic and authoritarian stance at times. In this situation there was not a clear legal basis for detaining the individual as S136 of the Mental Health Act had not been used, but all parties were in agreement that in that moment the necessary thing to do was to assess the person as quickly as possible.

One AMHP summarised how she viewed the role of the AMHP in terms of what is required when synthesising knowledge to make a decision:

> ***AMHP G 'There's a million and one decisions that are made in the back of your head before you reach one decision on a piece of paper and it would be very difficult to unpack those. But in lots of respects that's what we're expected to do, is unpack the psychology, the sociology, the circumstances for that particular person, the research and the practice and everything else, to make sense' (p40)***

Another AMHP also summarised how she views the AMHPs responsibility in terms of decision making:

> ***AMHP H: I think as AMHPs we look at things more in the round and look at someone's picture more holistically and look at family and look at support networks and I'm not sure all the medics do that. I think they get focussed on the criteria and risks and of course we look at that but we look at that more holistically, that's what the benefits are of the AMHP and our ability to do that (p36)***

AMHP D articulated the disconnect between what the MHA sets out and what happens in practice in situations where there is no bed available and other plans are made to manage the perceived risks until a bed is sought:

> ***It comes down to risk management but that doesn't click in with the Mental Health Act does it because ultimately if there was a bed you would be saying this person needs to be detained, but when you are saying this person needs to be detained you'd be formally completing the process so legally that person is a risk to themselves and other people. But that process just stops dead when there are no resources available' p12.***

AMHP H spoke of the MHA process being 'disrupted' by a lack of beds and articulated the dilemma or **'quagmire'** where there is a duty to assess but no available resources to facilitate an admission if necessary:

> ***I think, a lack of coherent plan of what to do when there's no bed for community assessments in terms of risk assessment and risk management, cause I don't think that's clear, I don't think that's clear' (p4)***

She describes taking steps to apply a '**sticking plaster'** when it is apparent an application needs to be made but there is no bed:

> ***But yeah, what least restrictive options can we draw upon that we've already deemed not to be viable, does that make sense, in the short term we try and utilise that or, again it depends on the situation but family play a huge role, carers play a huge role, sometimes it's about kind of, depending on the living arrangements, you're supporting them through that process and liaising with them' (p5).***

This extract supports the theme of professional identify and the sub theme managing relationships as the AMHPs interpersonal skills are drawn upon to negotiate and liaise with a range of 'players. AMHP H stated '**It's about relationships from the outset'** in terms of managing the uncertainty of an assessment.

The analysis identified the ways in which some of the AMHPs managed the disconnect between best practice and reality. For example, AMHP D described how when there is no bed 'you try and be a bit more covert about it [the purposes of the assessment]. This suggests that at times AMHP divert from best practice as a pragmatic and proportionate response to the resource pressures and barriers they operate within. AMHP D articulates this as:

> ***AMHP D 'You have to just do the best you can with what you've got really'. It's scary that increasingly there are no beds locally or nationally. You learn your priorities and you learn the bits that have to be done in the best interests of that person It's what we do, isn't it. You have to find your way around things to try and make it work' (p10)***

Another AMHP talked through an assessment where the decision was made not to detain – she emphasised her view that whilst there remained a risk that the person may become more unwell and place herself at increased risk of coming to harm, she took into account the individual's age, the availability of family support, and how to impose compulsory mental health services on her could lead to barriers in her recovery:

> ***'So, her risks weren't dramatic, she's just unwell and I can understand that a young person who has a psychosis, it is better to treat them with medication. But***

> ***sometimes you have to weigh that up really against, how restrictive is this really? Especially when the parent is saying I just can't see it being of any benefit, and they're the Nearest Relative'*** (p21)

This AMHP reflected on if her assumptions may have been different had the individual been an older person:

> ***Interviewer: 'Yeah, it sounds like her age was a factor in weighing up…***
>
> ***AMHP: Yeah, I think sometimes when somebody's reached a certain age, and you've got loads of, I mean, I probably shouldn't, you're going to record me saying this, I just sort of think, what have they got to lose, they've had it done to them so many times. But I always want younger people to have a better experience of mental health services, and I don't want them to be too traumatised by it, unless they absolutely have to be, in which case I won't hesitate you know? Get the police in, restrain them, do whatever we need to do, put the handcuffs in, throw them in the back of the van, admit them, inject them. If it has to happen. But if we can avoid it, I'll do it at all costs'*** (p23)

This extract speaks to the theme of power – and powerlessness. The AMHP implies that for those entrenched in an adult life of contact with mental health services, the cycle is already set in motion. But for younger people energy can still be directed to reduce this risk for them. It also captures an honesty around factors that are used and weighed when making decisions around admission. It also reflects the 'flippant' use of language that some of the AMHPs shifted into during the interviews and observations. To what extent this was due to the impact of my role as practitioner researcher is interesting to consider and could be given as an example of where being perceived by the AMHP participants as an 'insider' led to a frankness, or openness in what they chose to share.

5.9 Power and Powerlessness

The observations and the interviews elicited a clear sense of the pressures and uncertainty inherent in the role and the analysis explored why AMHPs want to continue working in these high pressure settings, arguably within a 'flawed system' due to the wider resource and structural barriers within mental health services. This can be considered as the ways in which

the AMHPs manage a sense of powerlessness. In some ways AMHPs speak of being thwarted by a 'system' that is beyond their control, but their sense of esteem and identity is built around findings ways to take back this control. The push and pull of power. This however is relative as conversely the AMHP role has inherent power in terms of the power to deprive an individual of their liberty:

> ***AMHP H: I need to be really clear as an AMHP that this is the only way that this person can be managed otherwise it's not fair to deprive them of their liberty. It's not fair on them as a person and I think it goes against your values and ethics in social work to be imposing that care and treatment, we need to be satisfied that this is the only way that this person's care and treatment can be managed really' (p29)***

Other power dynamics became evident during the analysis. For example, the power the AMHP has over deciding which other decision makers to accompany them on the assessment (although this power was then limited by the availability of the doctors).

AMHP G articulated her decision-making power regarding the choice of doctor:

> ***They need the right doctor there, the right gender, that speaks the right language. And we'll have that doctor over there because that one's going to talk sense, and we're not having this one, because he's going to sign the first piece of paper that lands on his desk. It's not about the first doctor at the top of the list. I do have a doctor at the bottom of the list, however, that doesn't get a phone call ever' (p11).***

There are also the dynamics between the AMHP and any involved family members. The Nearest Relative has a statutory power to object to an admission under Section 3 of the Mental Health Act and has the power to request discharge from a Section. The analysis suggests that the AMHPs awareness of the dynamics at play here is managed via interpersonal skills and negotiation.

For example, AMHP H outlined a scenario where a young person was experiencing signs of psychosis, hearing voices, highly distressed and not sleeping well. He was suspicious of mental health services and did not have a trusting relationship with any workers. However, he had family support around him who wanted to support him to start some new medication at home.

The AMHP spoke about how she took on board the families' viewpoint and balanced the risks:

> ***My feeling, yeah on that day I thought he's detainable yeah, but today I didn't think that an application needed to be made. Does that make sense? (p11)***

She also spoke of how she factored in the likelihood of the Nearest Relative exercising the right to discharge their relative and that she thought there was a strong chance of this happening:

> ***That would've set us apart from each other from the outset and it would've severed the relationship with mental health services I felt, from the outset. And also, she knows him well and I've met him once and she's known him and been caring for him for a while. She knows far better than me and in that respect it was opinion and I didn't, yeah, I didn't want that to be the first issue with mental health services where we disagree because I didn't think the risks were there, imminently today' (p11)***

This suggests that there can be a burden placed upon the AMHP in terms of managing risk and supporting individuals to remain 'in the community' even where the threshold for admission under the Mental Health Act is met.

Another relationship that the AMHP navigates in terms of shifting power is the ward staff and bed managers who it is necessary for them to liaise with during the course of the assessment. Again, the analysis identified how interpersonal relationship skills are employed to help these dynamics run more smoothly. One AMHP reflected on the negotiations to secure a bed:

> ***AMHP D: I just try always doing it in a polite calm way, you know, because it usually ends up in the best results I think. If you rock the boat sometimes people can say well I'm going to concentrate on this case over there instead, so it generally works – the polite approach' (p15)***

The data also suggests that the AMHP negotiates power with their wider organisations, in terms of what the statute requires them to do, how services are organised locally to support this and what they are being asked to do. This can include the support they receive from managers, the duty rotas, how often they are on AMHP duty, how large their other caseloads are. The analysis identified how local knowledge and networks are used to help smooth relationships with others and alleviate some of the contextual boundaries. An example was

the willingness of the assessing doctors to stay with the AMHP after the outcome of the assessment was decided but when the logistics of admission were still underway:

> ***AMHP C 'You know the ones that are flexible, you know the ones that you've got a good relationship with, and you know that they might stay with you if you need them to, so it's just an easier ride for me, and it just gives you a bit more resilience really' (p16)***

Another AMHP spoke of being left with the 'dirty work', describing some of the logistics that they felt left to deal with :

> **AMHP B: 'Yeah, so you can feel really stuck because you've got the responsibility for sorting out but you don't actually have the ability to do it.. So people say, well, that's the AMHPs..physical hospital say that the AMHPs responsibility, and it's like, yes but you've got the contact with the transport and all the numbers'** (p27)

Another aspect to power that was identified was the dynamic between the AMHP and the doctor in terms of decision making with some AMPHs distinguishing between those doctors who take a more traditional approach to understanding mental health and those who are more 'anti psychiatry'.

This was considered by one AMHP in the context of how nurse AMHPs may encounter and manage disputes with the assessing doctor:

> ***AMHP H: I wonder what the dynamic would be for nurses who have that kind of encounter with medics and there is very much a hierarchy despite new ways of working being really really old now, there is still that hierarchy where doctors think that their decision is the end decision (p36)***

Another AMHP also referred to 'hierarchy' and identified as being outside this structure:

> ***AMHP B: I think sort of contributing another point of view, another perspective. So I think sometimes its helps being outside the hierarchy of the health service' (p27)***

The analysis identified how AMHPs try and make sense of their power in terms of the legal power to detain an individual against their will, and how they then use this power. There was

a recognition of the impact of their actions upon the people that they assess. The data suggests that for the participating AMHPs a key role was how they acted as a 'buffer' from the impact of the MHA upon the person who is potentially going to be detained – making a traumatic situation as tolerable as possible.

> ***AMHP H: 'It's really important isn't it because you are in a position of significant power aren't you, and you have to look at equalising that as much as you can do I mean, the bottom line is you've got a piece of paper, if you have got recommendations, to make that person go to hospital. It's a huge amount of power isn't it. So, if you can kind of balance it out in anyway, you should do. And as well, just in terms of the emotional tone to it, that's really important as well. Because to detain someone you do it in as nice a way as you can do' (p13)***

AMHP G spoke of a 'mindset' that spoke to the theme of a sense of duty and empathy, 'putting yourself in someone else's shoes:

> ***'They're not a case number. They're not a shit report that you've got to fill in at the end of the day. That's a culmination of an experience that you've shared, and whether it's good or bad, in lots of respects, is your responsibility. And that's the mindset where you get – blowing my own trumpet – decent AMHPS. You go in with the mindset that that could be me, it could be my mother, it could be my Granny, and believe me, you treat them differently. That could be my baby boy (p47).***

AMHP H also identified the potential impact of being immersed in a role that focuses on being with people in crisis;

> ***I think you can easily get desensitized to what we see sometimes, not just as an AMHP but in the role of mental health and I think I'm aware of that and can reflect on that and show that it isn't affecting my decisions making, I think it's really important to do that throughout your practice really because otherwise I think you forget just how big and important a decisions it is 'cause it's huge, you know, families can get really really distressed and we need to ensure that we're doing absolutely the best thing that we can be doing for the person really (p29)***

This extract also relates to a sense of duty and what becomes the 'norm' in terms of the working conditions that AMHPs operate and make decisions within. One AMHP spoke about how other mental health professionals within the team are not motivated to train as an AMHP due to the long working days, potential risks and logistical challenges when carrying out the role. This suggests that others perceive the role as a very distinct aspect of mental health practice. This is explored further later in the chapter when exploring what motivates AMHPs to continue in the role.

AMHP D also identified the need to remind himself of the power he holds when carrying out an assessment:

> ***I've got to keep in mind that although I can't remember everyone I assessed, for them and their family they will never forget it - it's such an important thing to happen (p8)***

There was some reference to what other AMHPs do, in terms of a degree of criticism, towards the practice of colleagues for example that they would not challenge the doctors and be there to 'rubber stamp' decisions within a critique of the circumstances. This sheds some light on how some of the AMHPs identified themselves as 'other' and suggested that there is not always a sense of solidarity within the professional group. Another AMHP reflected on the 'turf wars' between professional groups and that AMHPs do not always appreciate the work that is carried out by other teams. This suggested a different perspective towards health colleagues:

> ***AMHP F: 'And I don't think they realise that the Crisis Team will move heaven and earth to get a bed. I don't think they realise the work that gets put in to do that, they just sort of say, oh there's no beds, and they never get us one, it's like, you didn't see that Health Support Worker sending 25 faxes or ringing round every single hospital that they can, especially if it's a high risk person in the community, they will do everything they can, and we need to appreciate that really' '*** (p16)

This extract also relates to the ways in which bed shortages have become part of the dominant discourse when citing pressures on the role. This suggests a more nuanced approach to this issue.

Conversely, the AMHPs also spoke about how their knowledge and role led to others valuing them more as team members, for example:

> ***AMHP H: 'I think certainly in this team I feel that I am, kind of respected and drawn upon for being an AMHP. I think we being something different in terms of upholding the social perspective and I think there's a lot of mileage to be had in terms of decision making, I think that makes a difference in having that overview from a social perspective and whether or not someone gets detained' (p34)***

One of the AMHPs spoke about how she always seeks more information to justify how the 'least restrictive' option is explored and why this is a key responsibility as a check to balance power;

> ***AMHP H: When they say "The least restrictive option is not viable" that's not enough for me, I want to know why they're not because…I don't think this has changed in terms of all the years of my AMHP practice in that even though I do assessments every day, I'm fully aware of the amount of power potential we have and that detaining someone is a really big thing, it's a really big thing for someone and it should absolutely be a last resort and that we are satisfied that we cannot manage this person in any other way and only then should we be looking at, you know, detention under the Act (p28)***

This AMHP also spoke about the AMHPs duty to challenge the doctor and how a clear sense of role and autonomy enables this conversation:

> ***'You do have to assert yourself and you know, it's how you go about that isn't it. I don't have a problem with that, I think if you do I don't think you can be an AMHP, to be honest because we have to offer that different perspective and say to the doctors, I disagree with you..I'm still very autonomous and will make a decision autonomously irrespective of what the medics are saying' (p36).***

One AMHPs response stood out as the exception as she spoke about actively wanting to assert the role in a way that could be perceived negatively by others:

> ***AMHP E 'I want to be an awkward AMHP, I don't want to be difficult, but I also don't want to be seen to be 'just saying 'where do I sign'. 'Cause in this city, as I'm sure there are everywhere, there's both you know? We've got AMHPS that will, sign wherever you like, and we've got AMHPs that will not make applications at all. Obviously they will, but they see it as a contest between them and the medics, or the first [medical]rec and the second rec, and I don't see it like that, you know?*** (p28)

This extract also sheds some light on the interface between roles and the potential for conflict and competition, going on to explore how she mitigates this:

> ***AMHP E 'So I rang the doctor that works on that team, so I didn't just ring any old Section 12 doctor, I rang the doctor that I know works with that team, and that he would know her history, and I also know that doctor as being a very thorough and very thoughtful, and slightly anti psychiatry doctor'*** (p20)

This use of role to overcome barriers also links into the ways in which the AMHPs operate as a 'buffer' to minimise the impact of the Act on the person being assessed, also aligned with the ways in which they are '**Being Human'**. The observations shed light on this but the AMHPs also spoke about this during the interviews in terms of the practical things they can do to support the person being assessed. Although practical actions there is a sense that these acts demonstrate respect towards the person:

> ***AMHP G: 'But it's about finding the thing that helps them – to go and pack their own bag, because actually if you're going to be in hospital, you want clean knickers, and you don't want them ones that are too tight, that don't fit. And you don't want that toothbrush that's been sat on toy shelf for the last six months, that you've not used because your other ones in your bag that you've been on holiday with. If you've got to go somewhere unpleasant that's what you want' (p43).***

When reflecting with AMHP B about how she helped make the person at the care home comfortable and assisted with putting her cardigan on she noted;

> ***'I think that's the bit that we bring to the assessment really as an AMHP. I think we…I do anyway. So it's distressing and even if people don't know that they're being assessed I think it's important to have that reassurance, that human element' (p6).***

5.10 Motivation to continue in the role

The analysis clearly identified the stressors of the role and barriers in terms of resource pressures. It also identifies the frustrations and challenges encountered by the participants. There is a potential contradiction as there is recognition from the AMHPs that to make 'good decisions' their wellbeing must be managed. The observations and interview data suggested a 'love hate' relationship with the role, such as the ambivalence about receiving an assessment referral on their duty day and the challenges they spoke about. As AMHP A asked to his peer during an observation: '**Why do we do this bollocks?'.** So, what motivates AMHPs to continue in the role?

> ***AMHP A: Well I still, I don't know, I kind of have mixed feelings about mental health services and I suppose the mix, I'm not always convinced that hospital is the best place for people experiencing mental distress. But it's almost a pragmatic view, a bit like I put in community support for people, you know like home care, and you know things could be far far far better for people and it's a bit rubbish often, but it's as good as it gets' (p11)***

Another AMHP (Participant F) cited the multiple roles and expectations placed upon him as one reason he sometimes considered stepping back from AMHP practice. But the motivation to help others led him to stay in the role:

> ***Well I mean, people being in distress isn't good. You should try and alleviate it in some way. I think we have if you are in that..I feel I've got some kind of responsibility if I can do, to try and alleviate it and even if it's not the ideal solution it's, like I said, as good as it gets' (p12)***

AMHP F said something similar:

> ***'Somebody's been really really ill there and you think..I like to think if I was really ill, I may lack capacity and be quite unpleasant with it, but I'd like to think somebody was looking out for me and hopefully I'd get better as a result of that. So you think it's quite a hard piece of work, but there's a beginning and an end to it. You're seeing people who are really really unwell aren't you, so that's quite satisfying, I suppose, to help people like that' (p18)***

AMHP D spoke about how the stress of the role in terms of barriers to accessing a doctor and a bed can lead him to have doubts about continuing in the role but that the adrenalin, thinking in the moment and working in a crisis setting is also enjoyable to him:

> ***'I had a moment the other week, I don't know what it was but we were arriving at the hospital and there were two police cars, there was the ambulance at the front and me and my car just sort of following all round this. And the, I was thinking "I did this" through phone calls and through all this was, sort of a process and I was kind of like "oh actually well that's quite good, it's all in a line, it's all organised in a line. Nothing terrible happened and it all…yeah that was quite a nice feeling like' (p20)***

AMHP H articulated her motivation to work in the AMHP role as:

> ***'I still really enjoy getting my teeth into the work, that's the work, that acute type of work that I really love'***

The analysis identified how for the participating AMHPS their motivation to work in the role could be distilled down to wanting to help people when they were at crisis point and relating their approach to how they would hope to be helped were they ever in that position. There is evidence of the use of empathy and consciously acting in a way that they hope would be reciprocated were they to ever be in the position of being assessed by an AMHP. There was also a sense of the satisfaction that can be achieved through managing the chaos and disorder of the assessment when some form of clear outcome is realised:

> ***AMHP D: The reason I keep doing it is because when you do a good job of it, you can see an immediate, something that would have ended in crisis and I've kind of, and yeah it's quite a dark motivation and that is the motivation just to do a good job. Which I think is probably why emotionally and in terms of anxiety, why resources have such an impact. Lack of resource because that affects your ability to do a good job and I think that's probably why it's such a stress factor. But yeah, it's certainly not for the money' (p18)***

It is interesting to consider why the AMHP describes this as a 'dark' motivation but the impression gained during the interview and the analysis was that there sits with this AMHP and across the participants a sense of guilt when talking about enjoyment of the role, as inherent in their work is an individual at the centre of all this who has been experiencing a very challenging time in their life. This loops back to the ways in which AMHPs mitigate the power inherent in the role.

> ***PBInterview: But there definitely are some rewards, I mean when I went up to the ward to try and take this letter to X, another chap jumped out and said 'Ooo thanks for, you know, thanks for all your help the other day, you know, for getting me in here'. It was great, it was this chap that we'd seen the week before who was totally, totally different, but remembered me and he was someone that we'd assessed in the 136 suite and admitted and you know, he was obviously doing really well and he, you know, I'd spoken to his family on the phone and he'd reconnected with them having been estranged from them and I sort of facilitated that a bit, I mean with his permission…..***

The analysis also identified how AMHPs gain an esteem from practising in the role, and the opportunity to be agents of a wider social change:

> ***'I mean I think if you can manage some kind of humanity in a situation then that's good enough. I think that is the change and that's the revolution' (p20)***

There was also a recurrent theme around a sense of duty and how they build their esteem around being autonomous practitioner, which for some creates anxiety but paradoxically also becomes a motivator to continue in the role:

> ***AMHP E 'I quite like the unpredictability; I like the acuteness of it. I like working with people, it sounds terrible, but I really enjoy working with people that are quite distressed, and being the person that they talk to, and that I can absorb it and reflect it back, and sort of make sense of it really, and I can calm that situation down' (p4)***

This sheds light on the reasons why practitioners continue to practice as AMHPs but also evidences something around the ways in which the uncertainty and chaos inherent in a MHA assessment, is mitigated.

For example, one AMHP spoke of enjoying the need to make lots of decisions in a short space of time and having to juggle the demands of various tasks;

> ***AMHP E 'I like that, I'm like firing at all levels, it's exhausting. It's absolutely exhausting work, and it draws on the skills you've got, you know, when you're training, your empathy, your compassion, the law, the Capacity Act (sic), what you might know about PACE (Police and Criminal Evidence Act), what you might know about Best Interests and capacity. So yeah, definitely, it pulls on all your resources' (p4)***

AMHP D identified a similar motivation:

> ***I like the….I don't know how to say it really – I like the getting it in, thinking, planning, doing all that, setting it all up, I do like all that kind of stuff. Going out, thinking on my feet, that's what I like. I like all that (p19)***

For another participating AMHP the nature of the work suited her in terms of managing workload and her wellbeing as she recognised that this type of decision making suited her:

> ***AMHP B: 'Yeah, I mean it is a weird sort of job, it's not the sort of thing to enjoy really. But I've found I'm better suited to immediate work, I'm not somebody that…it doesn't sit easily with me when I've got loads of different things hanging over me. I***

tend to take it home if I've got loads of stuff hanging over me, if I feel I've got this great backlog of stuff and people to worry about, yeah I find it a bit hard. I'm not very good at compartmentalising and separating work and life, so I find I'm just…I think immediate work does work better for me' (p7).

In summary, the analysis identified the dissonance for AMHPs in that what they found stressful about the role also motivated them to continue to work in the role.

5.11 Key Informant Interview

This interview was the final interview that I carried out and thus also served as a form of analysis as I was able to put some of my early findings to the participant, for her view. The contribution to knowledge of this section of the findings is:

- An account of the lived experience of an individual being assessed under The Mental Health Act
- A consideration of the limitations of the research design and ideas for future research
- Suggestions for practice – themes that emerged from this interview which also align with views from the literature around lived experience.

As an ethically accountable researcher this chapter has been set out as a stand-alone section of the thesis in recognition that traditionally this perspective has been given less weight in empirical research. The data was thus analysed within the individual data set of the interview transcript but then put to the larger data set which incorporated the observational and AMHP interview data where the themes identified within the AMHP data triangulated.

The interview followed the format of the interview schedule that I had gained ethical approval for, and the participant was given the 'Service User participant information' sheet and consent form. A criticism of research with so called 'vulnerable' participants is that the ethical consent procedure can take a paternalistic stance and make assumptions about the ways in which the voice of people with lived experience is presented. The participant had views about this, around having forums within which to tell her 'story' to health and social care practitioners and students:

> ***'That's one of the reasons why I like being on the user care group of the AMHP course, because I can use my experience and in a way it's like having therapy because you've had a bad experience, well not a bad experience about the AMHP, but the overall was a bad experience and you can get that across'***

The participant's standpoint is as an individual findings ways in which to make sense of and be empowered by talking about her experiences. It is not claiming to be representative of all

people who have been assessed under the MHA, but as will be explored in the next chapter, her perspective resonates with other accounts of this experience.

Perceptions of risk – how 'behaviours' are perceived:

The Key Informant spoke of what I have termed the 'insight paradox', a phenomenon whereby when an induvial asks for help it is not offered, but once they stop asking for help services perceive there to be a higher risk:

> ***'It was sort of like I'd gone past the point of wanting the help. I'd had months, maybe technically years because of all the ADHD diagnosis and then not having the diagnosis and then not getting the support, and then my son not getting the support'***

There was a sense she until she reached a crisis point, she would receive a limited response. In terms of risk assessment and AMHGP decision making it raises questions around how behaviours are perceived and why someone is doing what they're doing.

One AMHP spoke about the 'insight paradox' around grounds for admission to hospital:

AMHP B: ***'There might be some people who are seeking admission, often the people who are seeking admission may be the ones that don't need it'*** (p29)

It is interesting to try and understand what values underpin this statement in terms of what the extract says about the AMHPS perception of admission. There appears to be a contradiction in that those people who want to be admitted find it difficult to be admitted and those who do not are considered by decision makers to be most in need of admission. This sheds some light on perceptions around 'insight' but also indicates that the AMHP is weighing up information around risk to make a judgement on the necessity of admission.

One of the AMHP participants reflected on how behaviours can be perceived and interpreted as indicative of the person experiencing mental distress. The AMHP recalled a situation where over time they assessed an individual on numerous occasions, gaining an understanding of the ways in which certain behaviours were perceived;

> ***PG: 'And it's the time you take to build the trust that helps the situation. I don't ever have trouble with him. Other people think he's a bloody nightmare, but he trusts me'*** (P38

The AMHP reflected that this rapport has led to future situations de-escalating, rather than the police being called and neighbours watching as he was escorted out to a police car, eventually he would say to the AMHP;

> ***PG: 'I'm not right good am I? And I'd say no I don't think you are fella, what do you reckon? And he said, can we go in your car'?*** (p38)

The same AMHP spoke at length about taking the time to understand the basis of any unusual beliefs;

> ***[The woman was saying] I'm not paranoid, and actually she's not completely paranoid. She complains about the neighbours all the time, the neighbours are a pain in the arse, the neighbours are being absolutely horrendous to her. And we were investigating that. So, for me, it was about getting to the basis of, how much of this is paranoia, how much of this is real, what is the rumination, which is what she does, when something has happened. She ruminates and elaborates. And that's not psychotic'*** (p19)

Conversely Participant E cited a situation where a police officer had perceived an individual's actions as them being 'a troublemaker' and the AMHP in this situation took on the role of challenging this viewpoint and presenting an alternative perception of what was occurring for the person:

> ***'And that was somebody who didn't understand mental health, because he really treated her very badly when she was so psychotic. And he said, 'oh she's putting it on'. And I'm like she's not,'cause I'd met her before, I'd met her three weeks before, and I said, she's really unwell. And they just don't understand that people's behaviour changes when they're unwell. He thought she was just a troublemaker. Which she was as well, but you've got to take that into the picture, you know?'*** (p24)

The Key Informant Interview shed some light on relationships and engagement with professionals as well as a view on how she responded to being detained:

> ***'I wasn't engaging with anybody at the start [*of the compulsory admission*]. But the actual journey down I think I was engaging more engaging with the people at that point and then when I actually got to the hospital then I was very resistant to staff at that point. But I think when…I think I was more…probably more in shock or something, not feeling any strong emotion or anger about the situation'.***

The participant reflected on how with the benefit of time she sees her actions as a way to she was consciously making this choice;

> ***'One of the things which I did was I had a jug of water and I knocked it on the floor to..looking back now I was annoyed that I'd been ignored and stuff and if you knock a jug of water on the thing then you've got to be…people around and stuff. Even though I was..but I was more engaging with people at that point because I was asking for the help. But then when I was on the [psychiatric] ward I was very opposed to the staff. When I was an inpatient at the beginning and then you're monitored quite closely, but every time I'd shout and swear at the staff that came in, as soon as they came in I'd have a go, not physically but verbally, I'd just shout at them until they'd left'***

When considering the power and powerlessness experienced by the different parties involved in decision making the analysis of the AMHP interviews suggested that AMHPs recognise the ways in which their power impact on the people that they assess in that they takes steps to mitigate this power by demonstrating respect and maintaining the person's dignity for example. However, this extract provides an example of the ways in which the Key Informant identifies that she took back some control or 'power' over her circumstances in that her actions led to a consequence that she had significance influence over. What is of note and which requires further exploration is the ways in which these behaviours are perceived by AMHPs and other decision makers within mental health services. For example, are perceived as a sign and symptom of mental disorder, or as manifestation of a sense of loss of control and frustration?

Whilst the scenario described by the Key Informant was 'post admission', it is of relevance to AMHPs as they are making the decision that detention is the most appropriate course of action. This detention is for assessment or treatment of mental disorder and there is tension as to if a ward setting is the most appropriate place for someone to be when this emotionally distressed. This relates back to the comments from AMHP H around delaying an admission on the basis that detaining the person might have a detrimental impact on longer term relationships with mental health services due to breaches of trust.

5.12 Experiencing the assessment – what is important for the person? What 'sticks' in memory?

The Key Informant spoke about her impressions of the day of the Mental Health Act assessment that stick – she spoke about how it is difficult to recall what occurred on the day:

> ***Key Informant Interview: I don't recall too much of what went on. I think there were the two people, there was a woman who talked the most. They were trying to be helpful, they came across in a helpful way, and they did talk to me about what was going on, because they said oh it's [the ward] going to be female only' (p10).***

This provides an insight into the nature of the spaces that AMHPs can nurture to make spaces and 'be human' with people. It also highlights the challenge of the role in terms of how they make these spaces amid a challenging day with the contextual pressures that were outlined in the last section of this chapter. 'Helpfulness' defined as giving information and telling her what was going on were highlighted as the abiding memories. It is of note that she cannot recall the professions of the people she spoke with and did not distinguish between the roles. She also spoke about how she would travel to the hospital being very important to her:

> ***Key Informant Interview: I think what I wanted to happen was taken into account and what I wanted to happen couldn't be done, but then I was given the option of 'well we could do this instead' (p10)***

Her views around conveyance and a view around not wanting any personal items with her were identified as the Key Informant as being what mattered to her during the assessment and that she was listened to on these important matters. This extract suggests that the actions that AMHPs take to mitigate the power in their role, does have an impact on a sense

of the person being assessed regaining some sense of power and control over their circumstances.

The Key Informant also spoke about having reflected over time, and that she now perceives the assessment marking the end of one of the most traumatic periods of her life;

> ***'That was because I finally started to get the help on that day, so looking back on it with my perspective of today, it was like that's when I was finally listened to, but then what I'm thinking is why did everything have to happen first before things started getting taken seriously'.***

AMHP participant G spoke of skills she brings to the assessment in terms of hearing the voice and views of the person:

> ***'You've got to validate their experience, but get them to invite you in, and that's the key. It's not asking, it's that they want you in there, that they want you to understand them. And acknowledging that, actually, yeah, I can see that you might think your walls are blue. Do you realise that I think they're yellow? Do you know that we don't experience things the same? Is a lot easier than to go, 'you're talking nonsense'*** (p39)

This extract returns to the theme of 'Being Human' – the ways in which this AMHP finds a way to connect and listen to the person with the aim of building some trust and a rapport. It also links in with the theme of power and the ways in which AMHPS mitigate this power by being respectful and maintaining the person's dignity. The analysis also identified ways in which AMHPs make sense of a person's situation by considering the circumstances from the perspective of the person and using this as a basis to communicate using the same terms and ways of speaking about what is happening for that person.

Participant G also spoke about the approach that she takes when working with people with a diagnosis of Borderline Personality Disorder, outlining what she brings to these interactions. These can be considered as the values that underpin her approach in terms of the traits she utilises:

AMHP G Interview: ***Consistency, boundaries, empathy, support, openness, honesty. I'm not moving and this is where I am'*** (p40)

5.13 The AMHPs day as a journey

This analytical approach to understanding the nuances of the AMHP task and duties can be considered helpful as it illustrates the ways in which the themes elicited by the data inform an understanding of AMHP decision making. The discussion chapter outlines how this model could be of use to practice.

The proposed model uses the analogy of a car journey – an accessible way in which to outline the complexities of AMHP practice and incorporates all the themes and some sub themes as identified by the analysis across the data corpus:

The car park – choosing the make and model:

This is the start of the AMHPs duty day. The vehicle used to make the journey will be different dependent upon each individual AMHP as the car model type and its inherent attributes can be considered as the AMHPs starting point. This is informed by their **professional identity, professional identity, and practice wisdom**. Arguably the type of car used to make the journey will impact on the experience of the journey as this is the lens through which the journey is made. For example, a badly maintained car may need to make more stops or to refuel more frequently. Some cars perform better in traffic, others on a country road. Similarly, some AMHPs prefer certain types of assessment or situations and describe being better prepared for some scenarios over others.

Preparing for the journey

Before the car leaves the car park some items need to be packed – a map book, perhaps the highway code for a new driver, a satnav, and some food to eat. The fuel the AMHP needs can be considered the support they perceive they have access to, such as peer and manager support. It could also be the **resilience** they have to deal with the **uncertainties** ahead. The luggage the AMHP puts on board can be considered the **knowledge** they need, for example the Code of Practice and Mental Health Act manual.

Ready for the off – the traffic light turns green

This is the moment the referral is received, and the engine is no longer idling - the journey has begun. Early in the journey decisions need to be made about the route, which can be considered how the AMHP prepares for the assessment. The driver is not passive as they set off along a road. Whilst obstacles may arise the driver (the AMHP) is required to be reactive but also maintain some sense of direction by being proactive in the situation. There may be some anxiety at the start of a journey -what if I get lost, what if the roads are busy, what if I can't find anywhere safe to pull over and check the map? The AMHP also experiences anxiety and a sense of the unknown . They are required to **Manage Uncertainty and** draw upon all facets of **Professional Identity** to undertake the journey.

Any Passengers?

The journey may require stops to collect passengers. In most cases a doctor, but sometimes colleagues, the person being assessed, their family or friends.

The AMHP is required to decide about which passengers to pick up, for example via their preferences for and availability of an assessing doctor. At times they may ask a peer to accompany them if there are some concerns around risk. It might also be necessary to bring friends and family of the person being assessed along on the journey, particularly in situations where there is no identified bed and decisions must be made about the timing of the assessment and risk management. For example, when family members are asked to support their loved one when limited resources lead to delays in assessment and possible admission. The AMHP is required to use **Professional Discretion, interpersonal skills, and practice wisdom.**

Barriers: roadblocks, potholes – on some journey's events occur that end the journey prematurely such as a break down or road closure. In the working day of the AMHP these barriers can be considered contextual in terms of resource availability such as a lack of a bed, the person isn't home when they arrive to see them, or they abscond, and a different route is needed. The AMHPs **professional identity, approach to managing uncertainty and practice wisdom** inform how they barriers are dealt with. There are times on a journey when it is so well known the driver is surprised to find themselves at a road junction so soon, driving on 'automatic pilot'. It is also possible to miss a turning at a busy junction when the driver is

overwhelmed by information and options. In terms of the AMHP role this is characterised by the AMHP being distracted, or of finding it hard to concentrate.

Bridges – on a journey a bridge overrides an obstacle to make the journey possible. In terms of AMHP practice the 'bridges' they encounter during their working day can be seen via the networks and connections they have with others to ease problems and benefit from goodwill. These are driven and nurtured by the AMHPs **interpersonal skills, knowledge** about systems of support and resources around them – e.g. insider information regarding bed situations, good links with the referring team, and existing rapport with family members.

Short cuts – If a driver is new to an area, they are more likely to rely upon a map or to follow the directions on a sat nav. Familiarity with an area and local knowledge may enable a driver to take short cuts or back roads to arrive at their destination sooner. Professional discretion can be described as the confidence to deviate from the map and local knowledge, for example to apply discretion when following policy and statute. An example may be when an AMHP acts pragmatically to mitigate for resource limitations, deviating from best practice. The more experienced the AMHP the less they might refer to policy and instead adapt their approach to their own style. **Professional discretion** can be considered the places where they take more risks, overtaking or speeding. More cautious AMHPs may get the map out and consult. Even in a local area the Code of practice and MHA are like the highway code and map of the area - some parts more familiar, some less so.

Service stations, traffic lights and traffic jams

Motorway services are a place to pause, rest, eat, refuel, and plan the next part of the route. During a duty day the AMHP may build in these intentional pauses or reflective spaces to synthesise knowledge, consider their next steps and plan. This is a deliberate pause, driven by the AMHP as an opportunity to **make space and reflect**. There might be other pauses on a journey, driven by external factors, an enforced reduction in speed or temporary pause due to traffic lights, road works or traffic jams. During an AMHP duty day this would be characterised by time spent waiting for the referrer to call them back, waiting for a doctor to agree to accompany them on a visit, or waiting for information to inform next steps and decisions. Later on in the journey, after the assessment has taken place these stops could be caused by delays in securing police or ambulance support to convey the person to hospital.

Destinations – There is an initial destination at the journey's outset – to meet with the person who has been referred for assessment. Their location may be at a police station, at their home in the community, on a hospital ward. The AMHP must decide on the route to get there, who to take and what maps (knowledge) to use to inform these decisions. Once the assessment has taken place a second destination is decided upon – potentially a hospital ward but it also might be going back the way they came, to the office in the event that the grounds for detention are not met. It is in these places that decisions are made in relation to the application of policy to practice, informed by **knowledge, values, and ethics**.

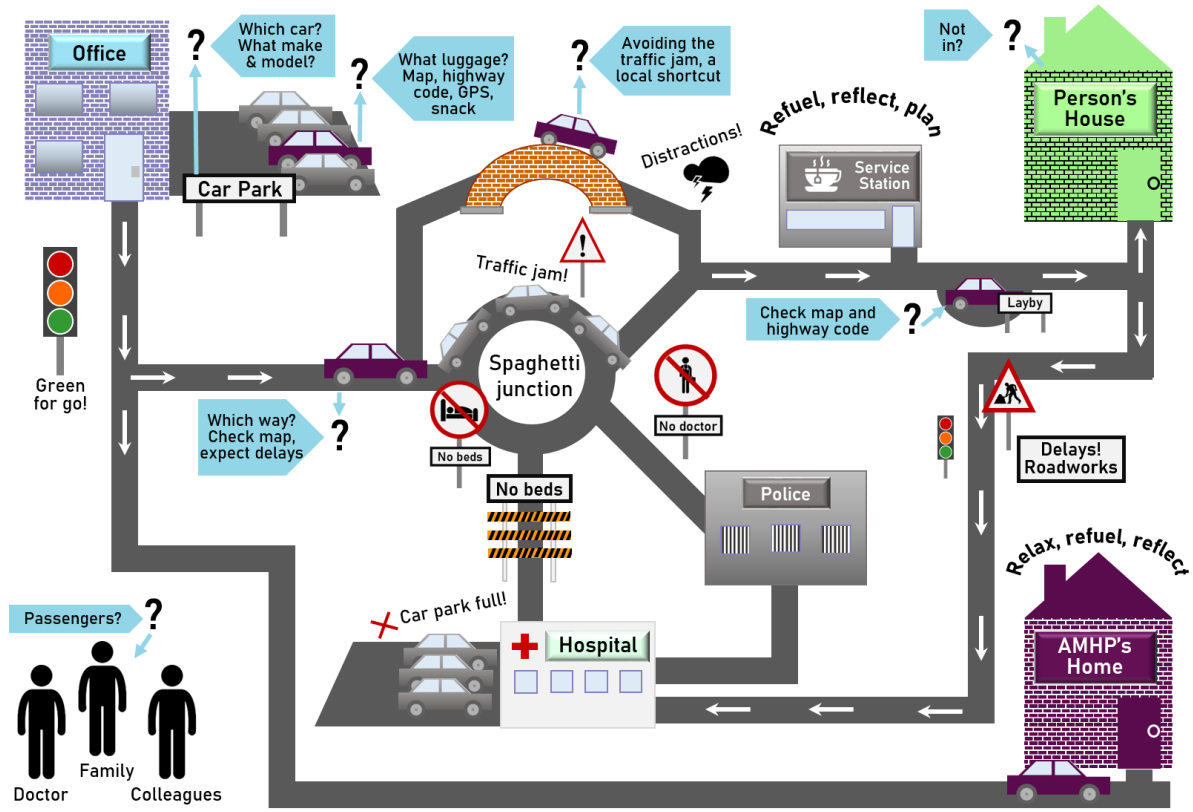
Adverse driving conditions: Bad weather, stressful driving conditions, icy, wet, needing the toilet – these all have an impact on concentration and focus and can lead to heightened anxiety and stress levels. Witnessing an incident on the road such as an accident can be upsetting and distracting, seeing human distress, '**Being Human'**. The driver might miss a turning, not be able to receive and synthesise all the necessary information needed to take the correct road. This has parallels with the impact of emotion on decision making for the AMHP, making it more difficult for them to make informed decisions and relying more on tacit knowledge.

Driving home and parking up at the end of the day – At a journey's end some time is spent thinking about the day and the destination. This is the time to decide where to park, for example close to home or a walk away. For the AMHPs this is **space to think and reflect** and marks the end of the duty day, for some delineating between work and home.

Fuel and maintenance

Wear and tear have an impact on the performance of the car and the potential to disrupt future journeys. For the AMHPs this wear and tear can be signified by the emotional impact of the AMHP role and their **resilience and wellbeing** plus the ambient stressors related to the role. It is necessary to add fuel to a car to keep it going and for an AMHP this fuel can be considered the factors that keep them engaged and motivated to continue in the role.

Figure 2: Pictorial Aid: The AMHP decision making journey



5.14 Summary

This chapter and the previous one have set out the themes and sub themes as identified through the use of Reflexive Thematic Analysis (Braun & Clarke, 2022). The analogy of a journey was used as an analytic tool to set out the ways in which AMHP decision making can be considered in terms of decision making in context. The next chapter explores the relevance of these findings and what they contribute to an understanding of AMHP decision making.

Chapter 6 Discussion:

This chapter explores the relevance of the research findings in terms of responding to the research questions and demonstrates the ways in which this is an original contribution to knowledge in the field of AMHP decision making.

The aim of the research was to explore AMHP decision making in practice with the objective being to explore how AMHPs are informed by the context within which they work and the ways in which they enact the statutory responsibilities of the role, and Guiding Principles of the Mental Health Act.

6.1 Research Aims:

- To explore how AMHP's generate and synthesise knowledge to make decision

- To consider if and in what ways decision making corresponds with the model of decision making outlined within the MHA Code of Practice's 'Guiding Principles'.

- To explore how AMHP's make the links between policy and practice in their work and what motivators drive these links.

- To identify barriers and aids to decision making within the context of a Mental Health Act assessment – such as the impact of time constraints, emotion and environment on decision making

As was discussed in the Methods chapter, the nature of the methods used to explore these aims enabled a richness of data that could then be analysed to identify key themes related to the research question and aims. A Case Study site was selected which was large enough to make recruitment realistic yet bound within the framework of specific geographic and service area. The area was unfamiliar to me within my own practice which set the scene to nurture an openness and curiosity to gain an insight, via the data, into the context of AMHP practice within this nuanced setting.

Whilst the data is specific to the practice of the AMHPs within the case study area, this approach enabled the research to focus on the nuance, depth, and detail of practice within a specific context that was shared by the participating AMHPs. As is outlined later in this chapter, the findings of this research align with findings from other AMHP research, and so can be said to offer a valuable and transferable insight into key issues experienced by AMHPs wherever they are based. In this way whilst the knowledge claims are specific to the case study site, they have relevance and offer research knowledge of AMHP practice and decision making more widely particularly that all AMHPS within England have as their starting point the Mental Health Act as a framework for practice. Thus, as was discussed in the Methods chapter when outlining epistemological and ontological positionings, the findings of this research are understood through the lens of a critical realist perspective – that being that whilst knowledge is context specific it is also informed by influences and social constructs that are relatable more widely. In terms of AMHP practice this could be characterised by the ways in which policy, statute, resource pressures and other factors such as power, are experienced by AMHPs wherever they are based.

It is also of note that in terms of the demographics of the participants, the AMHPs and key informant all identified as White British. A recent survey exploring AMHP identity received 258 responses from AMHPs of whom only 2.4% identified as Black/African/Caribbean/Black British and 1.6% as Asian/Asian British (Hemmington et al, 2021). Statistics evidence that in 2021 Black People were detained under The Mental Health Act at four times the rate of white people (NHS Digital 2022), continuing a long-standing trend in disproportionate detained rates. It has been suggested that one way to mitigate for this inequality is to increase the number of Black AMHPs (DHSC, 2022c). This research does not shed light on the experiences of Black AMHPs and it is important to highlight that as such the findings should be viewed as being limited to the perspective of white AMHPs, understood by myself as a White British researcher.

Within this context of knowledge claims and what the findings can offer to wider understandings of AMHP practice and decision making, this chapter examines some of these key themes to set out the ways in which the findings are situated within existing theoretical frameworks and models of understanding decision making and AMHP practice, threading throughout ways in which this has relevance to every day practice. Next, the findings are

considered within a contemporary setting, exploring current literature, policy, and statute to outline the continuing relevance of the research findings

The discussion addresses the following points, considering how the findings contribute to furthering an understanding of these issues in relation to AMHP decision making:

- Understanding AMHP decision making within the analogy of a journey – the relevance of space and place and the impact of emotion of decision making
- Exploring Virtue Ethics to understand practice wisdom: shedding light on values led practice
- Professional Discretion, Street Level Bureaucracy and using a Foucauldian concept of power to explore the AMHP role

6.2 The relevance of Spaces and Places for AMHP decision making

As was outlined in the previous chapter, the journey analogy to understand the complexities of AMHP decision making was developed as an overarching framework to pull the key themes together. This research uses the journey as an analytic tool, but this analogy also contributes to the growing research around Social Work practice as a fluid, in motion task (Ferguson, 2010). By shedding light on the nature of AMHP practice in this way the nuances and reality of day to day practice is highlighted. In terms of relevance to practitioners it also highlights the ways in which spaces and places can impact on practice, particularly as spaces to reflect and manage wellbeing.

These findings suggest that to understand AMHP decision making it is first necessary to develop a nuanced understanding of the contexts within which they work and the values that underpin their approach. The analogy of the journey connects the themes and sheds particular light on the importance of Places and Spaces when considering AMHP practice. The various environments within which AMHPS carry out decisions – in the office, the car, at people's homes, police stations and hospitals, serve as spaces where the role is enacted but also provide opportunities to reflect, interrogate and interrupt thoughts.

Considered in this was it becomes apparent that the theme of '**Spaces and places - the impact of emotion in decision making'** and '**Values and Ethics** closely align to form a proposed conceptual understanding of how these dynamics impact on decision making but also demonstrate something of the traits and qualities that AMHPs bring to their practice:

- The location of the assessment can impact on the emotional state of the AMHP. Short term this could make decision making more challenging as the AMHP may find it harder to concentrate or have the space to reflect in the knowledge gained to make a decision based on all available information. Longer term the impact of working in places with heightened emotion may on the resilience and wellbeing of the AMHP and motivation to remain in the role
- The AMHP demonstrates an approach to practice that has a particular value base driving decisions. For example, choosing quieter spaces to see the person, meeting them on more neutral territory such as a on the pavement.
- The AMHP makes decisions around pauses in their day to reflect, talk to peers, eat, refer to statute and the Code of Practice
- The use of space by the AMHP to delineate between work and home, finding ways to 'park' the emotional burden of work.

The findings identify the ways in which AMHPs find these spaces, for example the physical space of their car at the end of the day, or during a walk, or the metaphorical space of a break with a peer to talk over the day's events. This aligns with Ferguson's (2009) view that to practice more effectively Social Worker's working in Child Protection need to slow down and '*create stillness and moorings while on the move* (p576). Ferguson also explores the use of the car as a space to reflect and make sense of practice (Ferguson, 2010).

> *'Thus, cars have deep meanings for staff as spaces where the self can be replenished, and the supports and emotional resources needed to do effective social work can be built up. In addition to promoting personal safety through providing the means for a quick getaway from hostile clients, cars seem to provide an emotional comfort zone for professionals, a haven from the office politics as well as services users. It is a 'back-region' (Goffman, 1959) where the 'face-work' and demeanour required to conduct*

> *professional interviews can be relaxed and one can be 'oneself' again' (Ferguson, 2009, p15)*

The wider implications of the Coronavirus pandemic on AMHP practice are explored later in this chapter. However, in terms of place and space and the ways in which AMHPs utilise these to reflect on practice and manage the emotional burden of the role, there is growing recognition of the impact of the working environment on wellbeing.

Ferguson (2016) argues that Social Work is not a static profession, rather that it is in perpetual motion and thus research should be conducted that reflects the mobile nature of the role. Drawing upon the work of Kesserling (2006) his research focuses on 'mobility' within child protection Social Work of which there are parallels with AMHP work given both roles have the power to remove an individual from their home circumstances, against their will or the will of others. He states that:

> *'From the moment they left their desks and stepped out of the office and onto the street social workers were to a significant extent constructing their own practice in interaction with the environment, the family and their use of and experience of the car and the family home' (*Ferguson,2016,p5)

The analogy of the journey that was outlined in the findings section has practical use as a tool to understand the complexities of the AMHP role, but it also contributes to a developing understanding of the mobile nature of Social Work as a theoretical framework for conceptualising Social Work practice.

> *'While the movements of professionals are constrained in significant ways by bureaucratic demands and organisational dictates, as I have tried to show, when the staging of social work practices are also considered "from below" in terms of the lived experiences of social workers and service users, a much more nuanced, uncertain, fluid and dynamic characterisation of practice emerges. Beyond the office walls, in several ways the car and mobilities assist service users and practitioners to meet their aims and in some key respects liberates them to disclose emotional truths. Home visiting too requires creativity, courage and a capacity to cope with highly unpredictable work. Where children are kept safe it involves professionals moving towards them to properly*

> *see, touch, hear and walk with them to ensure they are fully engaged with and the risks to them uncovered. In crucial respects professional helping must be understood as work on the move'* (Ferguson, 2016, p15).

Arguably this approach as advocated by Ferguson has parallels with a Social Model of understanding mental health in that it recognises the strengths in being alongside an individual, on their terms and in their space. The theme 'Being Human' also sits alongside this as the examples given by the AMHPs had relevance to the spaces and places within which the AMHP was situated. The concept of being alongside also interplays with how AMHPs mitigate the power inherent in their role. For example, the AMHP who met with a young woman by the bins outside her flat, working creatively to form a rapport and speak with her on her terms or the observation of the AMHP who helped the older woman with her cardigan. Another example was the AMHP who recognised the impact of posting a note through someone's front door, delivering potentially distressing news within their home 'space'. This is explored later in this chapter when considering the relevance of Relationship Based Practice to these findings.

Banks (2018) also makes the connection between the dilemmas in social welfare practice and metaphor around places and spaces, drawing upon the literature that describes this area of practice as 'rough ground, swampy lowlands, and in relation to mental health practitioners the metaphor of practitioners tacking as if in a sailing boat, to tackle the rough seas. She refers explicitly to the qualities which are required to navigate metaphorical barriers and challenges and proposes that these qualities when taken as a whole can be considered to define professional wisdom:

> *'Whichever metaphor we use, however, the professional journey is fraught with challenges, and the ability of practitioners to navigate the turbulent context in which they work seems to require a range of human qualities such as mental agility, perceptual acuity, sensitivity to context, courage, commitment, good judgement, practical knowledge, collaborative working and appreciating the wider political context in which they operate. In philosophical and professional language such qualities have often been associated with practical wisdom (phronesis) and more specifically professional wisdom (Banks, 2018, p4).*

In terms of what the findings identify around how AMHPs develop an understanding of their value base and making space, the AMHPs spoke of becoming more comfortable in the role as they increased the theoretical knowledge in terms of the functions of the role – the statutory framework of the MHA. The AMHPs spoke about the role in terms of learning lines for a play, or learning to drive a car, analogies that suggest gaining skills that then enable them to take on a role in a play or use a car as a means of transport to get to a destination. In some senses the means to an end, with the desired outcome being able to comfortably enact the AMHP role to enable them to deal with the in the moment challenges and dilemmas that they encounter during AMHP practice.

The concept of practice wisdom can be considered a way of defining what it is that enables them to then practice in this manner. Adult Learning Theory such as Benner's 5 stage model (1982) can be drawn upon as a model of understanding this journey from 'novice' to expert' in terms of shedding some light on the transition practitioners make from 'learning the lines', when embedding theoretical knowledge. However, this does not necessarily articulate how a practitioner develops their 'ethical self', explored by Banks (2018) as Practice wisdom. One of the participating AMHPs reflected on the impact of 'burn out' and suggested that experience does not always enable an AMHP to make space to 'just be' with the person they are assessing. There was a suggestion that there is a mysterious, undefinable quality that AMHPs bring to the role. Gregor (2010) sought to characterise this as the 'emotional labour' of AMHP work but the concepts around virtue ethics seem to best encapsulate this essence of practice that the AMHPs spoke about.

6.3 The impact of emotion on decision making

The findings suggest that emotion has relevance for decision making both in the moment and cumulatively, in terms of the relationship between heightened stress and resilience and wellbeing. The findings also indicate that the stress and uncertainties inherent in the role in terms of the acceptance from participants that this was the nature of the job, are also to same factors that motivate AMHPs, maintain their professional identity and provide a sense of duty and esteem. Research from Watson (2015) exploring AMHP motivations to continue in the

role also identified the ways in which adrenalin and anticipation within the AMHP role serve as a motivator whilst also acting as a significant stressor.

Vicary (2020) used 'rich pictures' as a methodological tool to initiate discussions about the AMHPs experience of carrying out a Mental Health Act assessment, in terms of their emotional response. Interpretive Phenomenological Analysis was used to explore the meaning within the drawings each AMHP produced to represent these experiences. One image was of a 'whirring clock' to indicate the pressure of time, and another depicted a figure being pulled in different directions by competing priorities. She suggests one finding from this research with twelve AMHP participants from a range of professional backgrounds, is a sense of 'push and pull' in terms of experiencing both positive and negative emotions at the same time during the course of their AMHP work:

> *'Data indicate that a range of seemingly paradoxical emotions are present and crucially are experienced as co-existing, a dissonance which participants actively use to accomplish their role. As such AMHPs demonstrate sophisticated emotion management providing a new understanding of the part emotions play in AMHP work' (Vicary, 2020, p258)*

Vicary's findings have resonance with the findings from this research in terms of the ambivalence the AMHPs may feel when a referral is received in terms of the period of time when the assessment might not go ahead, but then this is resolved by a sense of duty and motivation to use their skills to manage uncertainty and resolve the barriers that might present during the course of their duty day.

The findings suggests that one of the greatest stressors on the role is not being able to complete the task as the AMHP would like, and how they manage this dissonance impacts on morale and resilience, which then impacts on their perceived capacity to make informed decisions. The research findings also identify the ways in which AMHPs recognised the detrimental impact of feeling anxious, uncertain, overwhelmed, or fearful during an assessment. Some of the AMHPs spoke about how they felt they did not make their best decisions at these times and may be more likely to miss key pieces of information. Research into the impact of effect on cognition (Blanchette & Richards, 2009) suggests that anxiety can lead to more risk averse decision making.

Considering the impact of this lack of fulfilment in the role also has relevance when informing discussions around the retention of the workforce, particularly within the current context of increased pressures. This dissatisfaction can be termed 'moral injury' in terms of the dichotomy when acting in ways that affront an individual's value base (Litz et al, 2009).

Austin et al (2005) explored the impact of 'moral distress' on Psychologists. This was characterised as situations where the participating Psychologist felt that their integrity was compromised due to contextual factors such as the demands placed upon them by the organisations within which they were based. The Psychologists responded in a variety of ways, one being to focus on the work with their clients to gain a sense of job satisfaction or seeking support from peers. Some left their roles. Austin et al (2005) propose that it is necessary to recognise and acknowledge moral injury within some roles due to the impact this can have on practitioners. More currently Romero-Garcia et al (2022) explore moral distress and moral injury in the context of Emergency Department nurses working during the Covid 19 pandemic in Spain and also found a link between practitioners feeling unable to fulfil their roles due to contextual constraints, leading to higher rates of nurses choosing to leave the role.

The Coronavirus pandemic arguably has led to a greater understanding of the impact of moral injury across the health and social care workforce in terms of managing the dissonance between the job a practitioner seeks to do, based on their sense of duty and value base, and what in reality they have to do. The DHSC created an Ethical Decision-Making Framework to accompany the Coronavirus Act 2020 to support practitioners working under The Care Act in a time of increasingly scant resources (DHSC, 2021b). The framework is accompanied by a set of principles to underpin decision making. There are comparisons between pressures in this context and the pressures upon the AMHP task in terms of the longstanding issues seen around bed shortages and reduced alternatives to admission due to limited community resources.

This does lead to the question, how can AMHPs be expected to make robust decisions in this situation? Is there a fundamental flaw in the AMHP role in that they are juggling too many tasks to meaningfully pay due regard to the key question of if someone should be deprived of their liberty to recent assessment or treatment under the Mental Health Act, as suggested by Hargreaves (2000) in relation to the Approved Social Worker role (the AMHP predecessor). Is there just too much for the AMHP to do?

What seems to be the consistent recommendation to counter or mitigate these challenges is the availability of reflective spaces, supervision, and supportive peers (MacClean 2020, Ferguson 2020, Singer et al, 2019). The findings from this research support these factors as being important in maintaining AMHP resilience and motivation to continue in the role and to feel they can effectively fulfil their functions as regards decision making.

6.4 Emotion and Relationships

One of the AMHPs spoke about how her relationships with people at times had led to a MHA assessment being diverted, as the crisis was alleviated through communicating and understanding where the person was coming from, using empathy to underpin her approach. The AMHPs also spoke about developing trusting relationships and thinking about the impact of their decisions on the longer-term outcome for the person, for example the risk that any trust and rapport might be damaged if a person was detained to hospital. This emphasis on valuing the importance of relationships when carrying out AMHP work can be described as relationship-based practice (RBP), an established theory within Social Work practice that has its origins in psychoanalytic and psychosocial models (Ruch et al, 2018).

Ingram and Smith (2018) set out the ways in which Relationship Based Practice is underpinned by practitioners having an awareness of self and an emotional intelligence towards how this self presents as and interacts with others.

They identify the challenges that this approach has faced considering the shifting paradigm within social care:

> *'RBP collides with and poses a fundamental challenge to managerial approaches to social work, foregrounding relationships, in all their ambiguity and messiness, above the bureaucratic, instrumental and ostensibly rational foundations of contemporary practice (Ingram & Smith, p12).*

In terms of AMHP practice there is an additional challenge to implementing this approach as the power is in the relationship is even more weighted towards the AMHP. The findings suggest that AMHPs do still utilise these skills which are characterised by the ways in which they make space to 'be human' during their interactions.

Kohli & Dutton (2010) and Ruch (2018) propose that even in more coercive settings such as Child Protection, or 'brief encounters' when people are experiencing crisis, relationship based

practice remains key to working in a way that promotes the rights of individuals as it promotes the creation of spaces to meaningfully hear what people have to say about their circumstances.

Smith (2015) carried out qualitative research exploring the experiences of Nearest Relatives during the Mental Health Act assessment of a loved one. A key finding was the impact upon the Nearest Relative of the AMHPs approach, in terms of the relationship that is formed between them. Referring to the principles of Relationship Based Practice Smith proposes ways in which this is positively experienced by the Nearest Relative participants in the study:

> *'Air, light and sunshine might be hard to find at the dark and difficult times that characterise many MHA assessments but the objective of helping nearest relatives 'breathe more easily and see more clearly' so that they can assume more mastery and control about the combination of circumstances they face should be valued' (2015, p14)*

This model of relationship-based practice can be seen to align with the concept of Virtue Ethics as both approaches seek to uncover the values and skills that practitioners use to underpin practice. In some ways it is an ontological positioning that then informs all aspects of practice whatever the setting. The research findings of this study suggest that the AMHPs key skill is making space to be with a person and allow these relationships to form even when under pressure, when the person is experiencing mental distress, and when in the majority of situations this is the first time that the person being assessed has met the AMHP. This can be considered the ways in which the AMHP sets the scene to actively listen and make space for the person to contribute to the assessment. Even if this is fundamentally to put the person at ease, mitigating the power imbalance, or making the space to consider the referral information from a different viewpoint, for example when making sense of the actions a person has taken and whether these are evidence of risk associated with mental wellbeing, or if there are other social or psychological explanations to consider.

Ruch at al (2018) argue that:

> '*In order to work in that way [relationship based], Social Workers require a distinctive kind of support and development, in terms of training, supervision and leadership, and that the organisational and policy contexts in which they have to operate will have a critical effect on their capacity to work effectively' (2018. p15)'*

This view aligns with the findings of this research, that supervision and reflective spaces have a key to play in maintaining the wellbeing of the AMHP and in turn ensuring they are emotionally able to fulfil the key functions of the role. This includes making space to 'be human, demonstrate empathy and promote the person's dignity. These traits align with the spirit of the Guiding Principles of the MHA in terms of the ways in which AMHPs empower and involve individuals in decision making and listen to their views as a means of demonstrating dignity and respect (DHSC, 2015, 22).

Whilst there was limited data to explore the experience of the assessment in terms of relationship, via the Key Informant Interview, the findings do suggest that 'helpfulness' and being validated were key memories in terms of the experience of being assessed. For example, listening to her preferences for how to travel to the hospital, and explaining why some options would not be possible. A recent study from Blakley et al (2021) interviewed ten participants who had been assessed under the MHA in the previous six months and who could recall the assessment. They note that there continues to be a lack of research knowledge focussing on the experience of being assessed under the MHA. One finding relates specifically to relationships in terms of the interaction with the assessing AMHP:

> *'Participants remembered and valued any positive interactions with professionals during the process: He (AMHP) had quite a calming demeanour … and he just listened to me … he wasn't like 'oh I've got to go in 10 min' kind of thing and I didn't feel rushed. (Alice) (Blakley et al, 2021)*

Findings from Smith (2015) exploring the experiences of Nearest Relatives during Mental Health Act assessments propose that

> *'Establishing connections with service users and their relatives does not resolve these complex and multifaceted difficulties but it does help people feel less alone when confronted with them. At least this constitutes a place to start from ..'* (Smith, 2015, p351)

This extract also has relevance to the findings in terms of how AMHPs use certain traits to mitigate power, as is discussed later in this chapter.

Findings from a systematic review of the literature around experiences of being assessed under the MHA highlight that 'fear and distress' were commonly reported experiences, mitigated when those involved in carrying out duties under the MHA formed 'caring and collaborative relationships' (Akther et al 2019). The research does not define at which stage in the assessment and detention 'journey' these experiences relate, as it may be that much of the research evidence gathered was whilst the person was an inpatient on the ward. However, this paper is of relevance to the findings of this doctoral study around how AMHPs make the 'space' to sit quietly with individuals, demonstrate empathy and compassion by actively listening to and validating their experiences, amidst an often-chaotic context.

The Centre for Mental Health (2019) in a position statement to influence Mental Health Act reform also takes a stance on the need to improve the experience of people being assessed and detained under the Act and highlight the role of relationships in this:

> *'Being sectioned, or seeing someone you care for sectioned, can be traumatic and distressing, with long-lasting consequences. But where both patients and carers are given clear information about their rights and what to expect, where staff build good relationships with them, and where the use of force is minimised, these experiences can be significantly improved'* (DHSC, p7).

6.5 The Impact of values on decision making

Whilst the findings suggest that AMHPs frame their decision making from a particular value base which manifests as displaying traits such as empathy, listening skills and 'making space' to be human with people, the findings suggest that it is also necessary to take a step further back when considering the assumptions that are made during decision making in the context of a Mental Health Act assessment. The AMHPs standpoint, informed by their personal and professional value base as well as their motivation and identity in the role, are likely to inform how they synthesis information to form a view on a situation. The findings suggest that the AMHP participants in this study took a critical stance to the assessment in terms of scrutinising the referral information and pursuing further information to make sense of and fill in the gaps which were often present in the initial referral information. There was a sense of not accepting information on 'face value' and seeking to explore the meaning of the information particularly around information related to risk, the prompt for the referral being made. There was also a sense of practitioners making decisions – small acts of rebellion - around the assessing psychiatrist based upon the robustness of their decision making and the time they would take to listen and consider the assessment. Some of the participants spoke of acknowledging that admission to a ward was not an ideal environment, but an acceptance that this was the current system. This reflects something of the moral injury outlined earlier, with some of the participants talking about how they think about how they would want to be treated, or how they would want a family member to be dealt with if they ever found themselves as the recipient of a Mental Health Act assessment.

Pilgrim's (2015) model based on Bourdieu (1977) uses the sociological concepts of *doxa*, *habitus* and *field* to explore underpinning dominant assumptions about mental health law and policy in the UK. *Doxa* in this context is a concept defined as '*traceable to Aristotle and refers to the taken for granted assumptions that operate in a particular cultural setting, or time, or place* (Pilgrim, 2015, p54). These assumptions include the necessity of compulsory treatment for mental health problems, that people can lack insight and not recognise their own need for help from services, and that a legal framework is required to clearly outline the ways in which this care and treatment is implemented. Pilgrim argues that an alternative set of assumptions could include:

- *The need for help is not self-evident in life. It is socially negotiated. It can be defined by others or by the person with the problems.*
- *Many people with problems do not seek help; this fact is not peculiar to those with mental health problems. Also, it is not self-evident that paternalism should be invoked legitimately when people are deemed to have lost their reason in the view of others. That invocation and the mandate for coercion it creates in particular cases are culturally-derived, self-reinforcing, self-serving and reflect particular contingencies during social crises' (Pilgrim, 2015, p56).*

Whilst the findings do not support the view that the participating AMHPs took an overtly critical stance to the systems within which they work, there was evidence of steps being taken to explore situations from the person's perspective and seek other explanations for their presentation. However, the findings did suggest that some held a view around people seeking admission when this was not required, although the data was limited in terms of the opportunity to explore this further within the analysis.

Of note around assumptions and the impact these have on decision making is the impact of available beds. The AMHPs spoke of the ways in which assessments were delayed at times or postponed with reliance on family members to support the person who was distressed. Data from the Coroner's Office evidences that in some regions in 2019 there had been delays of up to 29 days for a bed to become available (Cooper, 2021), and the Care Quality Commission report that in the year 2018/19 Coroners made them aware of at least 7 deaths amongst

people who were assessed as requiring admission but for whom no bed was available (CQC,2020).

The DHSC Chief Social Workers have recently brought this issue under further scrutiny, writing directly to Directors of Adult Social Services, Principal Social Workers and AMHP Leads to highlight the need, in relation to S140 of the Mental Health Act, for Local Authorities, NHS commissioners, police forces and ambulance services to ensure that they have a joint policy for the safe, appropriate admission of people in their area (DHSC, 2021).

In the meantime, the findings from this research provide further evidence that at the time of the fieldwork AMHPs were making decisions around when to assess, driven by the frustrations of not being able to identify a bed if one was needed. The findings also outline some of the ways in which AMHPs manage these delays. It could be considered that the momentum to assess on a particular day at a particular time is driven less by concerns around risk, but by the availability of resources. What is an emergency to admit an individual one day might have been managed as an alternative to admission on another with the only difference being the resources that were available. For example, in terms of the narrative of the person's journey, concern about their circumstances could be considered to only become an emergency if there is a bed, otherwise somehow the situation gets managed and there is a delay to assessment. Is the timing of the assessment resource driven or needs led? AMHPs are perhaps unintentionally upholding the 'least restrictive option' for want of another option. Whilst data from the Coroner's Office is a stark reminder of the impact of unmet needs, further exploration is required to understand if delays in some situations lead to positive outcomes for some people, for example a social crisis might ease and the perceived risks reduced by the point of the assessment. An individual also has more time to reassure professionals that they can be supported in the community rather than compulsorily on a hospital ward.

These ideas generated by the finding's links to theory such as those assumptions set out by Pilgrim (2015) and Goffman's (1961) work around the role of 'contingency' when understanding an individual's journey through mental health services. The findings suggest that resources, particularly bed availability, have an impact on the timing of assessment and that the timing is not dependent solely on apparent risks.

6.6 Professional Discretion and Decision Making

Evans and Harris (2004) in response to Lipsky (1981) consider the 'death' of discretion within the neoliberal managerialist context of social care. In terms of professional discretion, the AMHP role can be considered unique in that the AMHP is solely accountable for their decision making. They need to act in good faith to prevent individual culpability, as the employing Local Authority will take vicarious liability for any acts carried out in good faith. The statute therefore invites, to some extent, the AMHP to demonstrate discretion in terms of putting policy and statute into practice. There was a sense from the analysis that AMHPs did feel they were acting in isolation in terms of their decision making, in terms of the sense of duty they described. However, the duty was towards the person being assessed as opposed to the organisations within which they were based. The analysis did not elicit any data around the AMHP feeling influenced by hierarchy, rather that as Social Worker AMHPS they were inherently independent from the health service hierarchy. When considering the power in the role in terms of identity and fulfilling their legal duties, the analysis suggested that the participating AMHPs were accountable primarily to themselves and the person being assessed. For example, there was ownership of decision making and acknowledgement that context shaped the outcome of their actions at times, but that the stance of the participants maintained their independent role. This independence was almost a badge of honour and was a factor in the esteem associated with the role. There was some reference made during the observations to defensible recording and providing a rationale for their decisions, but this seemed driven by recording the ways in which contextual barriers had impacted on the outcome of the referral (e.g. when there was a delay due to a shortage of beds).

Evans and Harris (2004) explore professional discretion as *'a series of gradations to make decisions'* (p871) – this has relevance to the findings of this research when considering situations where AMHPs acted 'at the edge of the law' for example when working more 'covertly' and not giving an individual all the information that they were being assessed, to mitigate the impact of an application being necessary but a need not yet identified. This can also be considered during the situation at the police station 'the making it up as you go- along Act' to hold the person in the cells for assessment. This leads to further discussion around the motives of the AMHP when using discretion – the examples given by the AMHPs were

motivated by consideration for the wellbeing of the individual (although this is an example of when a viewpoint from that individual would shed more light on if this intervention was welcome or if the AMHP was exerting a more paternalistic, protective power than was not justified). These decisions can also be viewed as 'pragmatic' in the sense that the AMHP is making decisions in a short space of time with limited options. Hardy (2015) explores the notion of pragmatism in decision making and asserts that pragmatism is not 'value free' but rather can be characterised as decision making that draws upon knowledge based on a situated understanding of a particular situation, but that the decisions made are driven by a value base in terms of the desired outcome. '*What is best in a particular situation for a particular person'* (Polkinghorne 2004 in Hardy, 2015). This way of understanding AMHP decision making resolves some of the dilemmas that the AMHP participants articulated in terms of navigating contextual barriers and finding practical solutions to overcome them, whilst still driven by a sense of duty to maintain the 'spirit' of the MHA. It is a useful model to perhaps ease some of the tensions in the role in terms of how the AMHPs spoke about the stressors they experienced due to bed shortages or delays in identifying a Section 12 Doctor. Therefore, whilst they are limited in the available options, and make pragmatic decisions to overcome these barriers, the findings suggest that the motivation to overcome these barriers is driven by a value base that places the person being assessed at the heart of the assessment.

Taylor (2017) explores models of decision making and discretion and proposes that a useful framework for understanding decision making is the conceptual model developed by Simon (1956) that uses the metaphor of a pair of scissors in which the individual and the organisation within which the decisions are made form the two blades. Taylor advocates this approach as a contemporary way to understand human decision making in that both the individual and the context within which they make decisions must be examined to understand the ways in which decisions are made. This approach supports the conceptual understanding of this research in that to understand the AMHPs decisions it is necessary to know something of the context. This also supports the ways in which the data was gathered, via the observations which set out the nuances of practice, and the observations which enabled some sense to be made of how AMHPs talk about what they do.

Nyathi (2018) when exploring child protection Social Work using observational methods to explore 'real life decision making':

> *'Found that practitioners took into account a number of dimensions, including the consensus between professionals and with family members; the individual professional's state of mind; the priorities of other agencies and professionals; and organisational factors such as the availability of resources. He concludes that this use of a combination of intuitive heuristics and analytical thinking has the potential to aid our understanding – and hence our teaching – of professional judgement and decision-making' (in Taylor & Whittaker, 2018, p4)*

These findings closely align with the findings of this research, suggesting some parallels can be drawn between these two areas of practice and that these findings can contribute to an understanding of this conceptual understanding of decision making. For example, whilst Taylor (2017) urges caution in sole reliance on heuristics when making decisions there is acknowledgement that:

> '*What is required is greater clarity on approaches to the analysis of data in making judgements and decisions (Barlow et al, 2012; Taylor et al, 2015), and this might be supported by heuristic decision models. (Taylor,2017, p12)*

Nyathis's (2018) findings provide nuance to decision making in practice and suggest that intuitive or tacit knowledge is used at times of increased pressure when a decision needs to be made in a short time frame. The same could be said of AMHP practice with the participants in this research highlighting that they sometimes have limited access to information within which to make decisions. Time pressures arguably necessitate an increased reliance on 'intuitive heuristics. If this is the case, then an understanding of what informs these intuitions is paramount to further an understanding of AMHP decision making. Where a divergence does occur is in relation to the impact of emotion on decision making, with the suggestion that Child Protection Social Workers use discretion to defer some decisions to another time when they are more able to focus:

> *'By using discretion, it seems professionals are able to deal with different aspects of the case, depending on their anxiety levels or how mentally comfortable they feel handling the issues at hand. There may be some more complex issues that a professional feels ill-equipped to deal with on one occasion, which they would defer to another time when they feel better prepared (Nyathi, 2018, p9).*

This contracts with the findings from this research where the AMHP does not usually have time at their disposal to make a decision given that the referral is usually acted upon on the same day they receive the initial referral information. The findings also identify how AMHPs tend to work with uncertainty and in anxiety provoking situations most days. Again, this sheds light on the context for decision making which, according to the 'Scissor model' is integral when understanding how humans make decisions.

6.7 Power and the AMHP role

The findings of this research suggest that whilst AMHPs can feel powerless at times, they are still empowered to manage the uncertainty that they encounter during their working day, and that this powerlessness is relative, having parallels with findings from Buckland's (2020) research into AMHP practice:

> *'This snapshot of the ASW and AMHP literature has some echoes with the user, survivor and carer literature in the sense of powerless described by many AMHPs and a feeling of being part of a system with its own momentum. However, these feelings are negotiated from a position of relative and/or perceived power as the AMHP is the potential applicant for a hospital admission. This chimes with the general mental health social work literature suggesting that social workers will often experience themselves as existing in liminal spaces, between users and their families or between users and other, more medical staff. The enormity of their sense of significant power and simultaneous lack of power often appears almost paralysing' (p260)*

Tew (2006) outlines the contested and debated concept of 'power' more generally and specifically within the context of Social Work practice. He proposes a framework for understanding power as a matrix of power relations that can shift from protective to oppressive dependent upon the necessarily shifting and fluid dynamics within relationships . This is based upon a Foucauldian concept of power:

> *'That brings us back to the problem of what I mean by power. I hardly ever use the word power; and if I do sometimes, it is always a short cut to the expression I always use: the relationships of power. But there are ready made patterns: when one speaks of & people think immediately of a political structure, a government, a dominant social*

> *class, the master facing the slave, and so on. That is not at all what I think when I speak of relationships of power. I mean that in human relations, whatever they are-whether it be a question of communicating verbally, as we are doing right now, or a question of a love relationship, an institutional or economic relationship-power is always present: I mean the relationships in which one wishes to direct the behaviour of another. These are the relationships that one can find at different levels, under different forms: these relationships of power are changeable relations, i.e., they can modify themselves, they are not given once and for all. The fact, for example, that I am older and that at first you were intimidated can, in the course of the conversation, turn about and it is I who can become intimidated before someone, precisely because he is younger. These relations of power are then changeable, reversible and unstable'*

(Foucault, 1988, p122).

The findings of this research suggest that due to their professional identify and sense of duty AMHPs find ways to overcome their sense of powerlessness via the ways in which they take back control when the face uncertainty. Arguably of greater relevance from the findings is what these highlight about the ways in which AMHPs use their power. Tew's framework resonates with the findings from this thesis as a conceptual framework for understanding the ways in which AMHPs mitigate the power that they hold in terms of the power to detain someone against their will – seeking ways to use protective power as opposed to oppressive. However, Tew cautions that

> '*Deployments of protective power may easily slide into ones which are perceived as oppressive and disempowering by the recipients. Those in power may use their positions to enforce their agenda (however subtly) on those who may be vulnerable. Alongside this, any tendency to rescue rather than to work in partnership may stifle or further undermine the abilities of those who may already find it hard to mobilize power on their own behalf – and thereby serve to perpetuate, rather than combat, their experience of powerlessness' (Tew, 2006, p41)*

This caveat returns this discussion to the limitations of this research in terms of generating research knowledge from the viewpoint of those at the receiving end of an AMHPs power.

Looking to other literature, arguably this extract supports the importance of the MHA Guiding Principles in terms of participation in decision making.

> *'Invitations to co-operate and work alongside may potentially allow shifts from entrenched identities (such as 'expert' or 'victim'), and start to undermine social constructions of 'us' and 'them' – thereby opening up opportunities for all participants to enter into 'an active self-transformational process' (Fitzsimons and Fuller, 2002: 487) in Tew, 2006 p42.*

Whilst specific to discourse around power this does support the shift towards co-production within health and social care more widely - as advocated by the findings of this research in terms of shedding light on the research questions from all of the key stakeholders as well as shining meaningful light on values based practice.

Jobling (2016) explored the concept of coercion within the framework of Community Treatment Order's exploring power through the lens of Governmentality (Dean, 2009). Jobling suggests a more complex and nuanced way of understanding power and the relationships in which people subject to CTOs perceive the power the Order has over their lives. Individuals can experience dissonance in their feelings around the CTO and can both agree with the principles of the restrictions but also oppose the coercive nature of this which challenges simplistic cause and effect evaluations of the effectiveness of CTOs more widely:

> *'A governmental analysis of how service users think and act in response to disciplinary and coercive forms of power has implications for why CTOs follow particular pathways. The CTO cannot be understood as transformative in and of itself, but instead as acting in conjunction with ethical 'self-work'. Consequently, simplistic policy theories about the responses of 'target' groups to intervention cannot predicate what programme outcomes will be. It seems that both the multifaceted motivations and challenges service users bring to CTOs, coupled with the complex ways they interact with CTOs, mean such expectations are not always fulfilled' (Jobling, 2016, p18).*

The Informant Interview shed some light on the ways in which she 'took control' once admitted to a psychiatric ward, and how she felt her behaviours were perceived negatively by the ward staff. The findings provide some insight into the nuanced relationship with power

and compulsion experienced by one individual detained under the Act. This could also be explored further in relation to the 'insight paradox' and the ways in which power shifts within the dynamic of the MHA. Conceptualising this within the framework of Governmentalism is a helpful starting point to explore this nuance further.

In terms of the powerlessness experienced by the AMHP, for example the stalemate or being 'scuppered' due to bed shortages, the findings demonstrate that the burden is placed upon the AMHP in terms of managing the logistical challenges of an assessment. For example, even though the statute places the responsibility for locating a bed with the Consultant Psychiatrist, in practice it is the AMHP who holds the risk around delaying the assessment given they are responsible for managing logistics and orchestrating the assessment. The CQC report around use of the MHA in 20/21 highlights the responsibilities around finding a bed in practice remains a key area of ambiguity and pressure (CQC, 2022).

6.8 Critical Reflection upon the use of Power

Fook and Askeland (2006) suggest that critical reflection is a tool by which practitioners can explore the relationship between power and professional judgement:

> *'The Social Care workers who operate laws and regulations do not necessarily have to do so blindly but use their professional judgement. However, to use their power purposefully they must become conscious of it as a first step. This is one of the functions of critical reflection, to enable awareness of one's own use of power. A further function of critical reflection is to enable changed actions based on these new insights about the operation of power' (p44)*

BASW argue that a key role of Social Work is to have the legal literacy to enable them to inform those citizens that they work with of their rights (BASW, 2021). The findings from this research suggest that the AMHPs use legal literacy to mitigate the power they hold in their role as AMHPs alongside critical reflection on their practice. However, what is not clear is how much the interview process enabled this space for reflection and how much is entrenched in practice. The observation data suggests that AMHPs do value the space to reflect but there was variation across the AMHPS in terms of if the Guiding Principles were implicit or explicit in their daily practice and decision making.

6.9 Situating the findings in a contemporary context:

Since this research was designed and the fieldwork carried out, there have been key developments specific to AMHP decision making but also the wider context of Mental Health practice, in relation to legislative reform, policy developments and the focus of regulatory bodies on the AMHP role. The impact of the Coronavirus pandemic on mental health services is also pertinent. This overview explores recent research around AMHP decision making and evidences the continuing gaps in knowledge. I then set out how this research contributes original knowledge to the debate and highlight the ways in which this research can have impact given the timely nature of the findings.

6.10 Research - Current literature around AMHP decision making:

A key paper by Abbott (2021) takes a systematic review approach to appraise all the available research evidence exploring AMHP decision making. The author aimed to answer two key questions:

1. What processes shape social profession decision making about compulsory admission to mental health hospitals in practice?

2. What methodological approaches have informed studies in this area, and how have these shaped the current state of knowledge?

This paper has direct relevance to this thesis and the research findings as it takes a systematic review approach to literature, up to current times, specifically exploring AMHP decision making. This can be considered a reliable resource against which to consider recent research findings and the gaps that remain in terms of research knowledge. Abbott makes clear reference to the benefits, and challenges of shedding further light on the '*systemic processes that shape professional decision making in practice'* (2021, p13).

Using the time frame 1983-2020, and search terms 'AMHP','ASW' and 'Mental Health Officer' alongside 'compulsory assessment' 1738 papers were identified. These were refined down to23 papers with the inclusion criteria that they must include empirical data to inform the research questions of the review. The majority of these 23 gathered data using semi structured interviews and a relatively small number of participants. Only one used ethnographic or observational methods (Quirk, 2003). The findings of each paper were

analysed using a thematic analysis approach to broadly distinguish how they inform an understanding of decision making in this area of practice. These themes were cross referenced with the findings of each research paper and discussed with a group of AMHP practitioners to '*explore resonance of the emerging findings with their experience'* (Abbott, 2021, p5).

Key themes: Three key themes emerged that had an influence on how decisions are made:

Professional Positioning: This relates to professional identity, personal and professional value base and attitude, and degree of professional experience.

The paper outlines the ways in which AMHPs either frame their decision making clearly within a social model understanding of mental disorder, or in other studies where the role appears superseded by the medical professionals also involved in the decision-making process.

Characteristics of those Assessed: Refers to the research evidence that explores risk and risk assessment in terms of the presentation of the individual being assessed. There is evidence to suggest that men aged under 40 and from a lower socio-economic background are more likely to be assessed under the MHA, and that class and race also have an impact on the outcome of that assessment. The paper identifies that a gap in knowledge is the ways in which AMHPs actively identify the potential for these characteristics to bias the outcome of decisions, and how they may mitigate against, or challenge this in their practice.

Organisational Factors: The paper states that organisational – or contextual factors – have a significant impact on decision making in all the research findings. This includes the cooperation of other professionals, the availability of transport to convey an individual to a psychiatric hospital;

> *'The fact that necessary agencies may not be present (Morriss, 2016; Davidson et al., 2019; Leah, 2020) or, if present, feel under pressure to be elsewhere because of strains on resources (Bowers et al., 2003), creates the impression of a febrile environment for decision making, where logistics impinge significantly on the concerns of the social professional' (p10).*

The review has limitations in terms of a broad-brush approach to a wealth of, mainly, qualitative data, with a lack of transparency about the number of participants and how the

researchers interpreted the primary data. It is difficult to understand how the author 'weighted' the analysis of the themes that emerged from the review as the papers are listed to evidence a viewpoint. The papers also span a large time frame and explore the role of practitioners operating within different statute (e.g. Northern Ireland, Scotland, and England/Wales). Despite these differences the role and responsibilities of the social care professions have similarities in that they all have a duty to consider a 'social model' approach to decision making, and so inform an understanding of if and how this is done.

In the context of a lack of available beds or means of conveyance (e.g. police of ambulance assistance) the author comments;

> *'The importance of such logistical arrangements might also indicate that decisions are influenced by information known by the AMHP before the person is assessed in person. The literature does not explore this, illuminating a need to explore the temporality of such decision making' (p11).*

Whilst this is in the context of understanding the potential of systemic racism and the impact of race on the outcome of decision making around compulsory detention, it highlights both a gap in research knowledge due to the limited methods used in gathering data around decision making in this area of practice, and the benefits of taking an observational approach to data collection:

> *'Given the extent of racial disparity evident in compulsory mental health law decision making, the absence of engagement with this issue in the overall literature is striking. This resonates with Keating (2021), who points to diminished representation of the voices of black men in research. Future research needs to focus on the institutional context under-pinning this disparity, drawing on ethnographic methods to illuminate Responding to such gaps in knowledge entails practical and ethical challenges confronting researchers who wish to carry out ethnographic research in clinical encounters between professionals and citizens experiencing high levels of mental distress' (p13).*

The themes also hint at the nuances that lay beneath decision making, such as unconscious bias, for example when outlining the ways in which AMHPs cite tacit knowledge, or 'gut instinct' as a driver in decision making the author refers to a paper which interviewed AMHPs

stating; *'Buckland is wary of uncritically accepting this kind of individual 'common-sense' framing, drawing attention to how it can enable unexamined 'cultural bias' (p15).*

This paper evidences gap in the research literature that this doctoral research seeks to address via the findings. For example, the impact of bed shortages and the potential for this uncertainty to act as a stress, the relationship between this stressor and the resilience of AMHPs, and the pressures 'in the moment' when managing uncertainty. My findings also suggest that resources can impact upon outcomes for individual's. For example the AMHP considering how the news may be received by a Nearest Relative that the only identified bed is located a long way from a person's home, or how decisions around the risk of assessing when there is no bed are made. The research also explores the ways in which the AMHP participants identified with their role within an organisation, the motivating factors for taking on the AMHP role, and their decision to remain in that role despite the often cited pressures and demands.

There still only remains the Fistein et al (2016) and Quirk (2000) study that takes an observational approach to exploring decision making and the latter was conducted prior to the amendments to the Mental Health Act in 2007 that saw the shift from the Approved Social Worker role to the AMHP role. Due to the research methods used, my research contributes original knowledge to the topic and seeks to shed further light on an identified knowledge 'gap' that explores AMHP decision making 'in practice', in terms of what AMHPS actually 'do', with empirical data to evidence this in the form of reflective memos and reflective interviews. Having spent time getting to know the participants and observe their day to day practice argue that a strength of the data is the richness and depth in developing an understanding of the contexts that AMHPS practice within and how they respond to this to inform decision making.

A second key paper of relevant to this research was authored by key AMHP researchers and academics (Hemmington et al, 2021). It was commissioned by the Social Work regulatory body Social Work England established in 2020 and thus has influence in terms of impact and demonstrates some of the increasing focus and investment in research focussed on AMHP practice:

> *'Social Work England commissioned this piece of work as part of a commitment to learning about the professionals in these specialisms and people's experiences of them. The objective of this research was to undertake a study into the experiences of AMHPs and BIAs and those who have experience of their interventions. Existing research is generally inconclusive, and little is known about this area'* (p5).

It aimed to recruit AMHPs from all the eligible professions (Social Work, Occupational Therapy, Nursing and Psychology) and aimed to understand:

- AMHPs views and feelings on their identity in terms of their regulated profession, and the impact of this on their practice
- How views and approaches of the AMHP may vary across the different professions and the potential impact of this on the experience of the people they assess.
- The experiences of people assessed by AMHPs and if their experiences may vary dependent upon the regulated profession of the AMHP.

The team used surveys, focus groups and interviews to gather data, with 258 AMHPs responses to the survey, 21 AMHP participants across 4 focus group, 14 interviews with people with experience of being assessed by an AMHP, 2 interviews with people who had acted as Nearest Relative as defined by the Mental Health Act.

<u>The relevance of this paper to my research findings</u>

This paper returns to a research question that formed part of my initial proposal for the PhD – what impact profession has on AMHP practice. It was co-produced with people with lived experience. Interestingly, the researchers note that early on in this process it emerged that

> *'The planning phase indicated people may not know the professional background of the AMHP or BIA undertaking the assessment. We also know that AMHPs' and BIAs' professional identity is highly nuanced and is influenced by many variables including:*
>
> *• Professional (in terms of their regulated professional background as social workers, registered nurses, occupational therapists, and psychologists)*
>
> *• Organisational (for example, where team setting or type may have an influence), and*
>
> *• Personal (including where core values influence the work)*

> *The research team therefore developed a project that was designed to explore these various nuances and variables and to provide all participants with an opportunity to reflect on and discuss the nature of the work quite broadly'* (p6).

As I discussed in the Introduction chapter, my MA research had scoped this research question and I had decided to explore how any AMHP makes decisions in practice, as a starting point given the lack of research evidence considering this. This research supports my view that this was the right direction to take as there continues to be a low number of participants from non-Social Work backgrounds, and ambiguity remains about the role from those being assessed under the MHA:

> *'Perhaps of greatest interest is the perception that AMHPs disappear into the background, along with their role. People generally did not know what an AMHP was and, where they did, this knowledge did not appear to have been gleaned from a Mental Health Act assessment. Several did not know that an AMHP had been present in the assessment, despite their essential role as decision-maker and applicant. Albeit in a different context this mirrors AMHPs' own concerns about their invisibility, a concern shared by BIAs also* (p61)

Four key themes were identified by Hammesley et al (2021). Firstly, the invisibility of the AMHP role as perceived by AMHPs and supported by findings from interviews from people with lived experience of being assessed under the Act. Secondly, the stress and burn out experienced by AMHPs related to a conflict between a value base that aims to support people and meet their needs, but working within the limiting context of a lack of beds and availability of other resources such as means to convey the person to hospital. This linked into a theme around AMHP identity and the 'love hate relationship they had with the role. A final theme was around the importance of making space and time to enable the person being assessed to tell their story, in their own words.

The themes that emerged have resonance with some of the themes identified within my research analysis – particularly around making space and 'being' with a person, a quality highlighted by the AMHPs and the people with lived experience:

> *"Just gauge the mood of the patient […] and know as much as you can. Let the patient relax and tell their story […] And I think it's important not to ask questions from a list […] that detracts from the human level" (Hammersley, et al. 2021, p26)*

> *"One thing I didn't like is that the AMHP sat there scribbling all the time rather than looking at [me] […] Whereas the next time it was totally different. It was a discussion […] They listened to me […] Eye contact [is very important] […] It's about the conversation […] It's what I call 'a joint venture'"(Hammersley et al, 2021, p26)*

> *Having one-to-one time is really important […] if they're in your house [for a short time] then they've made their decision that's not good"(Hammersley et al, 2021, p26)*

This study does what I sought to explore but I was only able to recruit one person to participate– the lived experience of being assessed under the Act. Arguably, including this group as key stakeholders in the research reflects how the discourse has moved on during my PhD – a response to the growing acknowledgement that this area of knowledge and expertise has not been given sufficient focus historically. This is a valuable resource to shed light on the experiences of people subject to assessment under the MHA.

There were some reflections on the role of the Social Worker AMHP as a distinctive identity:

> *"Social workers seem to have a more social background and looking at us […] you know […] for the person […] The medical thing is what I'm against. 'Cause you've already got two doctors in there, you need one with a different perspective. If you put a nurse in there, which they can do, or a psychologist or an occupational therapist, they are kind of adding to the medical model"* (p28)

> *"It's about how they react. Social workers tend to be more laid back and chilled out, dress like normal people [...] Occupational therapists are even more [...] normal! Nurses are like medics […] If I'm off it the social worker will say 'what's happened'? The medical profession will say 'pop a couple of extra smarties"* (p28)

Other findings also highlighted a theme that has emerged from my data; the 'love hate' relationship with the role:

> *'Some AMHPs spoke about having a love/hate relationship with the role and, whilst many talked about how much they enjoyed it, they recognised that due to the*

> *propensity for burnout it was a time limited role. A clear and resounding message from many AMHPs is encapsulated as: "[It is] not a job that you can do alone for any sustained time, and I think it is also about burnout after all these years of this relentless […] chivvying and challenging* (p36)

The National Workforce Plan for AMHPs (DHSC, 2019) is referenced regarding the impact of the role on individuals in terms of stress, burn out and the consequences of supporting people who are often experiencing significant distress or trauma:

> *'Further, it recommends that 'AMHP supervision should be viewed as the cornerstone of quality AMHP practice' (p.33). Standard 4 of this plan is entitled 'AMHPs' personal, professional, physical and psychological safety' and here there is a recommendation that services 'ensure that AMHPs' safety and well-being is at the forefront of operational considerations' (p.33). Reference is also made within this report to ADASS' policy recommendations that AMHPs' morale, workload and work-stress issues should be monitored with partners at a strategic level, for example, with health and wellbeing boards* (ADASS, 2018). (p60).

With the changing context of Social Work regulation and the professionalisation of the role (more widely than just the AMHP role) AMHP practice has been given more focus and my findings also support the importance of regular reflective supervision to maintain wellbeing, resilience, and best practice. Over the past 18 months wellbeing and the impact on the Social Work workforce has been given even more focus, with the Chief Social Worker, a Statutory role based within the DHSC, making this a key priority for 21/22.

The contexts to practice outlined within this research have clear parallels with the context within which my fieldwork was situated, demonstrating that the themes that emerged from my analysis have continued relevance at the current time despite the fieldwork having been carried out in 2015/16.

6.11 The changing context of AMHP Practice: Policy and Practice

Since my research journey began in 2012 there has been some acknowledgement that the AMHP role has not received sufficient attention and that more should be done to promote

the role and ensure an equitable service via the introduction of National AMHP Service Standards. (DHSC, 2019). This has in part been driven by the introduction of the Chief Social Workers Office within the Department of Health and Social Care, and a new regulatory body for Social Work, Social Work England. This has seen a central resource to oversee practice development within Social Work and a focus on the different areas of Social Work Practice. The AMHP Workforce Development plan notes that:

> *The AMHP role is one of the most important in mental health. It is integral to the core services of both local authorities and NHS Trusts, and has an impact on acute NHS Trusts, ambulance services and the police. There is evidence, however, that it has not been given the full support, recognition, review and structure that it requires in order to be completely effective [The Association of Directors of Adult Social Services (ADASS), 2018; Care Quality Commission (CQC), 2018; King's College London (KCL), 2018; Stevens et al., 2018a].* (DHSC,2019,P3)

The BASW All Parliamentary Group on Social Work (2019) recommended that:

- *New mental health legislation should open with a definition of the social model and importance of the social determinants of mental illness … explicitly naming social workers as the key professionals doing this work (p4).*
- *A national data set on the number of MHA assessments (not just admissions), their outcomes, the age of the people assessed, ethnicity and discharge rates should be established by NHS Digital and Skills for Care (p10)*
- *New mental health legislation must have greater regard to both health and local authority resources to ensure compliance with legislation and human rights, including ensuring that local areas introduce a minimum number of AMHPs linked to population base (p7).*
- *CCGs should be held transparently accountable for their duties under Section 140 of the current Mental Health Act or its equivalent in new legislation, making sure that there are enough beds, enough children and young people's beds, and that AMHPs know where they are (p8).*

These aims reinforce the value of this research as the findings shed further light on areas they acknowledge require further focus in terms of staff support to maintain resilience, retain staff and ensure that training and supervision are regularly provided to support AMHPs in their role.

In terms of ongoing resource pressures, findings from BASW (2019) in response to the review of the Mental Health Act identified AMHPs giving evidence around high workloads, spending large amounts of time locating beds, reliance upon beds many miles from a person's home and the impact of a shortage of AMHPs in terms of feeling pressured to make decisions, and explicit reference to the negative impact this has on relationships:

> *AMHPs need time to make the appropriate, least restrictive decision for an individual; time to get to know them, to explain their options to them, to talk to family members and to come to a collaborative decision. In order to have that time and not be rushed onto the next assessment, there needs to be a sufficient number of AMHPs in every local area (BASW, 2019, P7).*

This evidences that the contextual factors explored in these research findings remain relevant in current times. The impact of the Coronavirus pandemic has further heightened the impact of these pressures:

> *Staff are now exhausted, with high levels of anxiety, stress and burnout, and the workforce is experiencing high levels of vacancies. The negative impact of working under this sustained pressure poses a challenge to the safe, effective and caring management of inpatient services and to the delivery of care in a way that maintains people's human rights (CQC, 2022, p10).*

Whilst referring to the raft of staff who work across mental health services, this explicit message from the regulator tasked with overseeing the use of the MHA reinforces the pertinence of the main research findings from this study. The CQC identify a direct correlation between staff wellbeing and their ability to maintain human rights. This research sheds light on the practice experiences of AMHPs working under pressure and how they articulate the impact of this pressure on decision making.

6.12 The Relevance of Mental Health Act Reform to the research

Alongside this research journey the MHA has also been subject to consultation, with reform looming. In report outlining recommendations for MHA reform Wessely (DHSC, 2018) sets out ways in which any reform should be underpinned by an emphasis on upholding human rights:

> *I am confident that our recommendations will "shift the dial", in favour of greater respect for wishes, choices and preferences. And I am confident that this has the support of all the stakeholders we have consulted. Research across the board, not just in mental health, has established beyond doubt that the greater the involvement of patients in decisions about their care and treatment, the better the outcome. I believe that these changes will increase a person's dignity, reduce the likelihood of unintended adverse outcomes, and reduce the risk of subsequent relapse. It will also go some way to overcoming the negative views that exist around inpatient psychiatric treatment (DHSC, 2018 p13)*

Arguably the recommendations outlined by Wessely et al (DHSC, 2018) mark a distinctive shift from the dominant debate during the previous Mental Health Act reform period as the focus is clearly on strengthening the rights of individuals subject to the Act. As was outlined in the Literature Review that situated the research at its outset, prior to the 2007 amendments the discourse around the changes were driven by concerns around risk, further to several high profile murders carried out by people with a mental health diagnosis, As Wessely states;

> '*Sadly looking back we can see that some of the decisions taken by government leading up to the 2007 Act were an overreaction'* (DHSC, 2018, p8).

The Draft Mental Health Bill was published in June 2022 with a response from the House of Lords due by the end of 2022. Commentators have stated that the reform will amend the existing Mental Health Act rather than rewrite a whole new Act. Early responses suggest that scrutiny will be made of why some the reforms advocated by the Wessely review have not been written into the Bill:

> *'The draft legislation adopts many, but not all, of the recommendations of the independent Review. Even where it does not adopt those recommendations expressly (as with the recommendation to place principles on the face of the Act), it can be seen*

> *in many cases to have 'internalised' those recommendations through the measures that it introduces to push practice towards greater respect for the rights, will and preferences[2] of those subject to the Act' (Ruck-Keene, 2022)*

It remains to be seen what the amendments will entail once they become statute but even if the principles are not explicitly enshrined in Law it can be argued that the dominant discourse around compulsory mental health care has shifted and rights based practice remains an aspiration. Again, to refer to Wessely:

> *'No one can fail to have noticed the change in public attitudes towards mental illness. Now positive stories about mental illness outweigh negative ones. Media headlines are always a good barometer of the zeitgeist, and some of the stigmatising headlines of the past are much less common, if not entirely a thing of the past' (2018, p8).*

How the obstacles that impede the successful implementation of this are overcome also remains to be seen. However, it is my view that these research findings contribute to an understanding of how rights-based practice can be translated to everyday situations that occur when people are assessed under the Act. The findings also contribute original knowledge to the debate that demonstrates that to make rights-based decisions, uphold respect and maintain dignity, key decision makers require organisational, emotional, and professional support to set the scene to do this.

6.13 The Impact of the Coronavirus Pandemic on AMHP practice

The context within which AMHPs operate has been significantly impacted upon by the consequences of the Coronavirus pandemic. In terms of use of the MHA it may be that the pandemic exacerbated existing pressures that led to an increased use in the MHA. The Care Quality Commission's annual report on use of the MHA states;

> *'NHS digital statistics on the use of the MHA, published in October 2021, while incomplete, suggest that during 2020/21 the overall use of the MHA increased by about 4.5%.1 This rise may in part reflect reduced access to community mental health services during the pandemic. It may also be that the reduction of inpatient bed capacity at the start of the pandemic led to an increase in the use of the MHA for the*

> *remaining bed capacity. This is not new; the impact of reduced bed capacity on use of the MHA was noted over a decade ago' (2022, p7).*

It is significant that the CQC focus their monitoring report on the experiences of people once detained to a hospital ward. Their monitoring report does not include a review of the assessment that leads to someone being 'liable to be detained' i.e. once the AMHP makes an application for detention as AMHP practice is outside their regulatory responsibilities as they are employed by Local Authorities rather than Heath services (CQC, 2018).. This practice still seems to go on behind closed doors and receives less scrutiny than the experience once someone arrives on the ward for assessment and treatment.

There is also increasing evidence around the impact of working from home, a key feature of the pandemic. A BASW (2021) survey of the Social Work workforce found that

- 71.5% [of 1119 participants] of respondents agreed or strongly agreed that the Covid-19 crisis had adversely impacted workplace morale in their place of employment.
- 68.3% of respondents agreed or strongly agreed that working from home during the Covid-19 crisis had made it more difficult for them to switch off from work.

McFadden et al (2021) also explored the impact of Covid 19 on the Health and Social Care workforce via a large-scale workforce survey with 2721 respondents from health and social care setting across the whole of the UK. According to this study, one Social Worker 'felt that working from home "negated it being my "safe place" after a difficult day" (p37). A follow up study in 2022 explored the ongoing impact on staff wellbeing of working from home:

> *Respondents referred to the absence of spatial boundaries to explain their inability to 'switch off' at home (McFadden et al, 2022, p42).*

Ferguson has commented specifically anecdotal evidence around the impact of fewer commutes for work:

> *I'm hearing that practitioners are finding it particularly hard at the end of the working day not to have the journey home to process all the experiences and feelings that have come up, a transitional experience that leaves the mind freer to relate to partners, family, friends. (*Ferguson,2020)

These reflections are pertinent given the likelihood that AMHPs are also working more frequently from home in terms of writing up reports and planning workload. Further insights are required to explore the impact of this on wellbeing and resilience, but the findings from this research suggest that being situated amongst colleagues and peers was a vital emotional support for the participating AMHPs.

6.14 Summary

This chapter has explored the findings from the analysis and considered how they contribute to existing knowledge around AMHP decision making, and the ways in which these findings contribute original knowledge to this field. The relevance of recent changes to policy and practice alongside the impact of the Coronavirus pandemic was set out.

I worked within adult social care during the Coronavirus pandemic and was responsible for delivering practice guidance around use of statute within this context. When talking to practitioners about rights-based practice there was a sense of people feeling overwhelmed, under stress and struggling to manage large caseloads. We spoke about how the relatively small actions can have an impact – sharing information, listening – basic social work skills and that arguably it is in these 'small places' that rights are upheld as the scene is set for collaborative working with the views of the individual respected and given prominence. This research contributes to a model of approaching practice that is underpinned by virtue ethics and rights-based practice in that it demonstrates how this is operationalised in practice, the motivation of practitioners but also the organisational barriers that limit the scope of individual practitioners. It also suggests that whilst the outcomes of assessments in terms of rates of detention are understandably the 'headline' news in terms of the AMHPS role in use of the Mental Health Act, that the decisions along the way, from the point of referral, also have an impact on the final outcome and also the experience of assessment for that person. Contrasting the 'headline' decisions around decisions to detain an individual or to remove a child from the care of its parents, Taylor (2018) notes '*It is important to recognise that we make countless decisions everyday in our professional lives that are less high profile but which can be as important*' (p1). These findings support this view. For example, the way in which an AMHP approaches an assessment may have consequences longer term around ongoing

trust and relationships with services and when making sense of a moment in their life when control and power was removed.

It can be argued that in terms of day to day decision making the AMHP role is more protected from the influences of local priorities, and organisational agendas as it is an independent role. However, in practice this independence and discretion is limited by the options available. These findings are reinforced by recent research from Leah (2022) who explores the notion of AMHP practice as a 'Fool's Errand' in terms of being placed in situations where there are limited options to fulfil their role due to the resource pressures. The AMHPs sit with this moral injury and work resourcefully to overcome barriers and uncertainty. The findings from this research contribute to a developing understanding of how those charged with upholding rights enact this day to day, providing an insight into what usually occurs behind metaphorical closed doors. In terms of a review of statute and the impact of any amendments that aim to strengthen the rights of individuals, research of this type is essential to demonstrate the meaningful ways in which statute translates to practice. The findings also strengthen the viewpoint that whilst practitioners may have a will to uphold the Guiding Principles, they must also have access to the resources – the way – to fully enact these principles.

In terms of AMHPs carrying the burden of organisational challenges, a developing model of considering resilience from an organisational rather than individual's responsibility is offered by Considine et al (2015), who propose a Social Model of resilience. They critique what they perceive as a move towards increasing expectations on individual Social Workers to maintain their emotional resilience as a professional standard. This supports the findings of this research in that resilience and the threats to resilience are more nuanced in practice. For example, the findings suggest that the participating AMHPs finds ways to cope with the demands of the role as laid out by Law e.g. mitigating use of power, application of values etc, but when they are limited in exercising the role due to external factors this is cited as a stress. Rather than considering it the individual's responsibly to maintain their resilience in these circumstances arguably the organisations within which they are situated should bear some of this burden and ensure the contexts within which AMHPS operate are supportive.

Chapter 7 Conclusion

This concluding chapter provides a summary of the thesis content. It sets out the limitations of the study which in turn fuel ideas for future research. Next, I outline a set of recommendations for practice, policy and research methodology based on the findings and their relevance as detailed in the previous chapter. I also state the ways in which this study is likely to have impact both now and on future research and practice in the context of the AMHP role:

7.1 Limitations of the Research

As was explored within the Methods chapter, after 18 years as a qualified Social Worker and nine years as an AMHP I am entrenched in the world of Social Work practice and thus see the work of practitioners through this ontological and epistemological lens. Whilst I aimed to adopt a reflexive approach to the analysis as outlined by Braun and Clarke (2022), being explicit in my standpoint, there is the potential that the analysis was influenced by a confirmatory bias – the lens through which I analysed the data. For example, how would the same data have been analysed and interpreted in different hands? Arguably this is a fundamental ontological and epistemological challenge in post graduate research when the work is undertaken, and 'owned' by one individual in terms of accountability for the study. Discussing the assessment with the person who was assessed after the event was also an attempt to hear the voice of that person in the reflection or early analysis of the event.

This research had lofty aims in terms of increasing understanding of values-based practice and the perspective of people with lived experience. On reflection this was a high expectation within the scope of post graduate research particularly given the hard to reach area of practice that was the research focus. For example, as was discussed in the Methods chapter, it took a year to gain ethical approval for the project. To overcome these barriers, one way to develop this would be to either expand the research over a wider geographical area taking an action research approach such as people with lived experience carrying out the interviews and analysis, or focussing on the AMHPs practice by taking an observational approach but

limiting this to time in the office with the AMHP. This would reduce the barriers around gaining ethical approval but would maintain the benefits of observing practitioners 'in vivo' and also develop those relationships which arguably lead to a deeper level of reflection and openness about decision making and the application of values and ethics to practice in terms of content of the data.

My original intention was to explore decision making from the perspective of all those involved in the decision but primarily the AMHP and the person being assessed. In part this was driven by my own practice experience when I had conversations in the course of my Mental Health Social Worker role, with people who had been detained, or were subject to Community Treatment Orders. What came across to me was the impact of the loss of control and the sense of not being listened to. For example, the voices of families being heard above the person being assessed, or pieces of information given more weight than others which led to certain decisions being made. If space was more routinely made for the AMHP and the person who was assessed to come together at some point after the assessment arguably this could enable questions to be asked and some control returned to the person, particularly if the assessment is considered a traumatic event. I had hoped that these research findings would contribute to furthering understanding of how reflecting together in this way can be of benefit. Had the design gone to plan this would have enabled analysis of data from different viewpoints and would also give voice to a perspective that is less often heard.

One benefit of the passage of time since this research journey began is that perspectives have shifted and the views of those with lived experience are becoming more prevalent in the discourse around mental health care and statute reform. For example, 'co production' is now an often-cited term that is referenced in the CQC's annual reports and the review of the Mental Health Act. The voice of people with lived experience is threaded throughout these reports and given increasing weight.

At the beginning of my studies I read a paper by Le Grand (1997) which argues that there has been a shift in how policy makes perceive the motivation of those engaged in the welfare state. It proposes that people can be distinguished as Knights (motivated by altruistic intention), Knaves (self-interested individuals) and pawns, that is, passive recipients of the state. This viewpoint informed my thinking as I recognise that my bias is towards believing that AMHPs are unlikely to be motivated by the money or the power inherent in the role. An

early example of my shifting perspective during the analysis was my at worst, naivety, at best, readiness to expect that all practitioners give their optimum when fulfilling their role. It was my view that all AMHPS share at least some fundamental values that they weave through their practice.

This bias could be seen to manifest as influencing the analysis. For example, during the fieldwork when the AMHP spoke more informally, used more disrespectful language, or applied a creative use of the Law, I chose to understand this as them using a safe space with peers to diffuse some of the tension and anxiety they experienced fulfilling the role. I also understood this as having 'good intentions towards the person they were assessing and using discretion to pragmatically overcome contextual barriers. However, I recognise that it is a naive view to assume that all AMHPs enter the profession as Knights. To use Le Grand's (1997) definitions, those AMHPs that err towards knavish inclinations were unlikely to participate in a study which involved such close observations – perhaps perceived as scrutiny - of their practice.

Some of the AMHPs referred to 'other AMHPs' who perhaps were more likely to 'rubber stamp' a decision, or 'go along with the doctor' but I did not find evidence of this via the analysis of the data. This is an area of practice that could be explored via Fitness to Practice complaints to the Social Work regulator Social Work England, or via the CQC and is a whole other research project beyond the scope of this thesis.

The richness of the data led to an in-depth analysis that could have been considered from a different standpoint, for example the ways in which risk is perceived and understood. This was limited as it was not possible to use all the data gathered due to issues around consent from those being assessed. Also, as I was unable to recruit participants to be interviewed amongst those whose assessment, I had observed it was not possible to shed light on risk from the standpoint of all parties. An area to explore and understand is how the view of the AMHP around risk relates to the perception of the person who was assessed. This perspective would also serve as feedback to the AMHPs in terms of reflecting on their practice. For example, an AMHP may identify as and consider themselves to be an ethically informed practitioner, but this perception may contrast with how the person being assessed perceived the individual or the role.

Similarly, an AMHP may aim to underpin their work with the Guiding Principles but who is best placed to assess this and make a value judgement? The perspective of the person would have shed much light on this and enable an analysis of how AMHPS perceive their practice and how it is experienced by those the decisions are being made about.

7.2 Equality and Diversity

The Centre for Mental Health (2019) in their work to set out key issues around use of the MHA, to inform the MHA reform, call for a greater emphasis on 'co-production' between services, individuals, and carers to improve positive experiences of admission. It also takes a position on the need for future research to explore the ongoing inequalities in terms of the characteristics of people detained under the Act (e.g. race, socio economic status) and to increase understanding of the possible drivers behind an increase in mental health issues across the population. The work carried out by The Centre for Mental Health, exploring research to inform Mental Health Act reform sheds light on variations on use of the Act in terms of the characteristics that increase likelihood of being detained, these being a diagnosis of psychosis or bi-polar disorder, perceived risk to others (as opposed to risk to self, another criteria for detention under the MHA), and being male, single (or previously married), a non-home owner and unemployed or in receipt of state benefits (2019).

A future research aim would be to shine a light on the practice of a broader range of AMHPs including those from black and minority ethnic backgrounds as the participating AMHPs were all white British origin and I am a white British woman. Some of the people whose assessments I observed were from black and minority ethnic groups but due to issues around consent to use the observational data around the specifics of the assessment there were limits to the analysis.

In the context of MHA reform Wessely, (2018) explores bias in terms of its impact on decision making, specific to race and stereotyping:

> *I believe that those motivated to go into a career in mental health rarely do so out of desire to make lots of money (there are easier ways). I would like to believe that they are more likely to have attitudes and experiences that ought to make race thinking and stereotyping less likely. But I have come to accept that this is not always true. Even though my respect and admiration for my fellow professionals persists, I recognise that no one is completely free from biases, and all of us can have feet of clay (2018, p12)*

The data did not shed light on structural inequalities such as class, race, disability, socio economic status or other protected characteristics as outlined in The Equality Act in terms of the impact of these characteristics on AMHP decision making. There was reference to age being a factor with AMHPs sharing their concern about detaining a younger person into the mental health system, recognising conscious bias. This is a limitation in the research design as the interview scheduled could have included questions explicitly around the issues of race and mental health. Had I designed the research in more recent times, with my own growing understanding of anti-racist practice (Bhatti Sinclair,2011), I would have ensured a focussed lens on equality and diversity. In terms of rates of detention, black and minority ethnic people continue to be disproportionately represented (CQC, 2022) and there may have been missed opportunities during the production of this research to contribute to developing an understanding of this.

7.3 The Contribution of the Research to Researcher Methodology

As was outlined in the Methods chapter, the process of gaining ethical approval was lengthy, and the observation methods employed required ongoing consideration of issues around consent.

Banks (2018) proposes some key traits that would identify researcher integrity including:

> *'Recognising situations where virtues are relevant; seeing the ethical issues at stake from multiple perspectives; managing and engendering emotions; working on ethical identity (e.g. becoming and being a respectful/honest person); working on relationships with research participants and other stakeholders; undertaking practical*

> *reasoning, including working out how to act; taking action; questioning critically the currently accepted values and standards of research (p7)*

Arguably the 'doing' of this research, as described in Chapter 3, has contributed to the growing body of knowledge around this concept, demonstrating the barriers when navigating an ethically sensitive area of practice and reflecting at each point of the process to revisit, for example informed consent.

I suggest that many of the traits considered to demonstrate practice wisdom can be transferred to the researcher role, demonstrating the value of Practitioner Researchers.

7.4 Ideas for future research and the relevance of the research for Practice

Whilst the research question is specific to how AMHPs make decisions, this research sits within a broader research context and arguably contributes to the development of knowledge around the ethics of practice, primarily virtue ethics. Policy and statute places increasing emphasis on the 'principles' within which practitioners are expected to operate, alongside the regulation of professions and the requirement to adhere to Professional Standards (Social Work England). As Banks (2018) and Kinsella and Pitman (2012) outline, this can be operationalised as a procedural or tick box exercise, that lacks depth to evidence the values and relationships that occur in practice. The Chief Social Workers Office (DHSC) has advocated the implementation of a new set of standards for supervisors which includes emphasis on feedback from people with lived experience. (Skills for care, 2018) and Social Work England also require registered Social Workers to submit at least one piece of 'CPD' annually that includes peer reflection. This research suggests that reflective spaces are key to enabling AMHPs to practice in a relationship based way and whilst it contributes to an understanding of how practitioners use values to inform decision making, future research, using observational methods could explore the impact of the implementation of these new Standards for Social Work.

In their response to the Mental Health Act White Paper in 2021, the National Service User Network make a pertinent point regarding the implementation of any new set of Principles embedded in the amended Mental Health Act and made the link between values based practice and the conditions necessary for this to be implemented:

'Much of what is proposed in the White Paper depends upon sustained investment and consistent funding of community services, primary care and the NHS itself overall. However, over the past decade, mental health and social care services have been through continuous and brutal cuts, and there are few signs that there is the political will to reverse this in a meaningful way and plug the numerous gaps in service provision. In this context, our view is that introducing these changes to law before the elements required for the changes to function as intended represents too great a risk.

We also draw attention to the set of guiding principles in the current Mental Health Act Code of Practice (least restrictive option and maximising independence; empowerment and involvement; respect and dignity; purpose and effectiveness; and, efficiency and equity) and question the extent to which any revised principles will be monitored and enforced in practice' (NSUN, 2021).

Further research is required to understand the most effective ways in which to evaluate values based practice although developments in the co-production paradigm would suggest that gaining the viewpoint of those whose lives were impacted upon by an individuals practice should be a key voice in this reflection and evaluation. Arguably this feedback is an essential component of any meaningful review of a practitioner's work. Pawson et al (2003) cite 'service user and carer' knowledge as having equal standing in the types of knowledge that good quality social care research should seek to generate. Any future research and evaluations of practice should prioritise developing knowledge from the standpoint of those at the receiving end of MHA assessments.

In 1958 Eleanor Roosevelt addressed the United Nations in a speech about the implementation of human rights:

'Where, after all, do universal human rights begin? In small places, close to home – so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; the neighbourhood he lives in; the school of college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerned citizen action to uphold them close to home,

we shall look in vain for progress in the larger world' Eleanor Roosevelt to the United Nations in 1958

This echoes the concerns raised by the National Service User Network – that it is the 'small places', the everyday places and interactions where human rights are upheld. Arguably to know anything about the degree to which Human Rights are being upheld it is necessary therefore to focus the lens on practice in these every day, routine areas of practice. The findings from this research project shed some light on the ways in which AMHP decision making occurs in daily practice and how values and motivations can influence decision making. However, the findings also lead to ideas for future research to develop these ideas.

In summary, grand plans around Guiding Principles and Human Rights based practice as written into statute (or not) arguably have little meaning unless enacted in practice by key decision makers, but how can we know that this does happen? Sarah Banks' (2018) work around Virtue Ethics both for practitioners (and researchers) as a model for understanding the types of knowledge AMHPs draw upon when making decisions and the impact of values on these decisions, plus Lipsky's (1980) ideas around Street Level Bureaucracy, and Evans & Hupe's (2019) and Evans (2020) development of these within a contemporary context, help inform an understanding of why understanding practitioner values is key to understanding the ways in which knowledge is synthesised to inform decision making.

- Future research could explore how organisational commitment to regular reflective supervision impacts on practitioner's wellbeing and resilience, but also how this then enables space to reflect on the values that underpin decision making.
- The AMHP journey analogy could be developed into a tool for reflective supervision and an evaluation of its effectiveness in supporting practitioners to reflect on ways in which their standpoint and values impact upon decision making, with a tool for gathering feedback from people with lived experience, built into the reflection tool. This would enable some insight to be developed around how people experience the approach and decisions that AMHPS make from a values-based perspective, in the case of the MHA specifically around the Guiding Principles for example. An AMHP might think they practice from a human rights-based model but how did the person

being assessed experience this and thus what can be learnt from this to improve practice.

- The journey analogy model could also be used as a methodological approach to carrying out research to further explore AMHP decision making. Similar to the 'Rich Picture' approach taken by Vicary (2021) this analogy could be developed into a research tool for interviewing AMHPs about the role in terms of their decision making, the contexts and challenges they encounter, and what motivates and drives their practice from a values based perspective. This would enable further research knowledge to be generated around the concepts of virtue ethics (Banks & Gallagher, 2009).

7.5 Recommendations for Practice:

- The findings can be provided as evidence of the benefits of relationship-based practice in promoting the Guiding Principles. Aligned with this is the link to ensuring practitioners have access to regular reflective supervisions.
- The AMHP journey analogy could be used as a training tool to raise awareness of the complexity of the role and the impact of this complexity on decision making. The audience for this could range from students, trainee AMHPs, AMHP supervisors and line managers, senior strategic managers, and policy makers. This would align with the aims of the AMHP Workforce development Plan (DHSC).
- The AMHP journey analogy tool could be used as a prompt for reflective supervision or as a resource for AMHPs to record their reflections on practice as per the registration requirements of Social Work England or other regulatory bodies for non-Social Work AMHPs (e.g. the Health and Care Professions Council or Nursing and Midwifery Council).

7.6 Impact

Given the ongoing consultation around Mental Health Act reform and recognition on the need for employers to implement effective reflective supervision for employees across health and social care, it is my intention to summarise the findings of this paper and submit this for publication in an academic journal. Given the findings have resonance to inform and

contribute research knowledge to an area of practice that is under closer review, ethically I have a responsibility to share the findings and disseminate them widely. Alongside academic journals I have provisional plans in place to present the findings to the National Principal Social Worker Network, and researcher and practitioner conferences as appropriate.

7.7 Final Thoughts

This research has been percolating for a long time now for a variety of reasons predominantly related to the commitments outside the boundaries of academic life. However, it is serendipitous that the findings arguably have even more relevance in current times given the ongoing reform of the Mental Health Act, focus on rights based practice and more specifically, focus on the role of the AMHP (BASW, 2019, DHSC, 2021a, DHSC, 2022). The literature specific to AMHP practice and decision making was fairly limited at the outset of the research design. Arguably, the investment and focus in AMHP research in recent years has served to explicitly highlight the areas of practice that are under researched or which rely upon anecdotal evidence (Hemmington et al, 2021, Abbott, 2021).

In terms of impact the findings of this research are topical, relevant and there is a focus on this area of practice from the Department of Health and Social Care, The Chief Social Worker and the National AMHP workforce via Skills for Care and the regulatory body, Social Work England. The pandemic has sharpened the focus on the mental health needs of the wider population but also the impact of lowered resilience and wellbeing on professional decision making (BASW, 2021, CQC, 2022, McFadden et al 2021). The findings of this research provide research evidence to contribute to the debate around how working under stressful conditions impacts on decision making and makes suggestions for practice as to ways in which this can be mitigated via improved support for AMHPs. The findings also demonstrate the challenges in understanding what motivates professional's decision making and the values that underpin these motivations and perspectives. However, the research offers a framework to understand this via the notion of context and providing spaces to reflect and articulate what informs professional decision making. It suggests that by casting a lens on the every day of practice meaningful evidence can be gathered to inform the effectiveness and implementation of rights-based practice, and the barriers that infringe on this.

References:

Abbott, S. (2021) 'Decision Making by Practitioners in the Social Care Professions Involved in Compulsory Admission to Mental Health Hospital: A scoping Review' in *British Journal of Social Work,* 52 (4)

Akthar, S, F, Molyneaux, E, Stuart, R, Johnson, S, Simpson, A. an Oram, S. (2019) 'Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis' in *British Journal of Psychology* 25 (5)

Allen, R. (2013) 'Social Workers: The Forgotten Emergency Service' in *The Guardian Professional* (http://www.theguardian.com/social-care-network/2013/jul/31/social-workers-forgotten-emergency-service)

Austin, W. Rankel, M, Kagan, L, Bergum, V. , G. (2005) 'To stay or to go, to speak or stay silent, to act or not to act: moral distress as experienced by psychologists' in *Ethics and Behaviour* 15 , 3

Banks, S. and Gallagher, A.(2009) Ethics in Professional Life: Virtues for Health and Social Care, Palgrave Macmillan, Hampshire.

Banks, S. (2018) **'**Cultivating researcher integrity : virtue-based approaches to research ethics' in Virtue ethics in the conduct and governance of social science research. Bingley: Emerald, pp. 21-44. Advances in research ethics and integrity. (3).

Banks, S. (2018) 'Practising professional ethical wisdom : the role of 'ethics work' in the social welfare field' in Carr, D. (ed) (2018) *Cultivating character and virtue in professional practice.* Abingdon, Oxon: Routledge.

Barnes, M. and Bowl, R. (2001) *Taking Over the Asylum: Empowerment and Mental Health*, Palgrave.

Barnes, C. (2019) 'Understanding the social model of disability: Past, present and future' in Watson, N. and Vehmas, S. (2019) (eds) *Routledge Handbook of Disability* Studies (2nd edn), Routledge.

Blakley, L, Asher, C, Etherington, A, Maher, J, Wadey, E, Walsh, V. and Walker, S. (2021) 'Waiting for the Verdict: The Experience of Being Assessed under the Mental Health Act' in *Journal of Mental Health*, **31** (2)

British Association of Social Workers (2004) *Mental Health Bill Update – July 2004*, Unpublished document sent to BASW membership.

BASW (2019) *All Parliamentary Group on Social Work: Social Workers and a New Mental Health Act: Final Report*, BASW.

BASW (2021) Social Work During the Covid 19 Pandemic: Initial Findings, BASW.

BASW (2021) The Role of the Social Worker and Legal Literacy: Homes not Hospitals, BASW.

basw_social_working_during_the_covid_19_pandemic_initial_findings_26.01.21.pdf

BASW, DHSC (2020)The impact of the Covid-19 pandemic on Approved Mental Health Professional (AMHP) services in England

Benner, P. (1982) 'From Novice to Expert' in *American Journal of Nursing*, 82, 402-407.

Bentall, R. (2004) *Madness Explained: Psychosis and Human Nature*, Penguin Publications.

Beresford, P. (2013) 'Experiential knowledge and the reconception of madness' In Coles, S, Keenan, S. and Diamond, B. (eds) (2013) *Madness contested: Power and practice*. PCSS Books Ross-on-Wye.

Beresford, P, Nettle, M, Perring, R. (2010) *Towards a social model of madness and distress? Exploring what service users say,* Joseph Rowntree Foundation.

Bhaskar, R. (1978) *A Realist Theory of Science*, Harvester Press, Brighton.

Bhatti-Sinclair, K. (2011) *Anti-Racist Practice in Social Work*, Palgrave.

Blanchette, I. and Richards,A. (2009) 'The influence of affect on higher level cognition: A review of research on interpretation, judgement, decision making and reasoning' in Cognition and Emotion First Published 299 August 2009

Bordieau, P. (1977) *Outline of a Theory of Practice,* Cambridge University Press.

Bowers, L, Clark, N, Callaghan, P. (2003) 'Multidisciplinary Reflections on Assessment for Compulsory Admission: The Views of Approved Social Workers, General Practitioners, Ambulance Crews, Police, Community Psychiatric Nurses and Psychiatrists' in *British Journal of Social Work* (2003) 33 961-968

Bressington, D. T., H. Wells, and M. Graham. 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

Buckland, R. (2014) 'The Decision by Approved Mental Health Professionals to Use Compulsory Powers under the Mental Health Act 1983: A Foucauldian Discourse Analysis' in British Journal of Social Work 46 1

Buckland, R. (2020) 'Power as Perceived in MHA Assessment Contexts: A Scoping Review of the Literature' in *Social Work in Action* 32 **4**

Braun, V, Clarke, V. (2006) 'Using Thematic Analysis in Psychology' in *Qualitative Research in Psychology 3 (2)*

Braun, V. and Clarke, V. (2022) *Reflexive Thematic Analysis: A Practical Guide*, Sage Publications Limited.

Brewer, J, D. (2000) Ethnography, Open University Press, Berkshire.

Brown, P, Calnan, M, Scrivener, A and Szmukter, G (2009) 'Trust in Mental Health Services: A Neglected Concept' in *Journal of Mental Health* 18 (5) 449-458

Campbell, J and Davidson, G. (2010) 'An audit of assessment and reporting by Approved Social Workers (ASWs') in *British Journal of Social Work (2010)*

Campbell, J. (2010) 'Deciding to Detain: The Use of Compulsory Mental Health Law by UK Social Workers' in *British Journal of Social Work* (2010) 40 328-334

Care Quality Commission (2013) *Monitoring the Mental Health Act in 2011/12*, The Stationery Office.

Care Quality Commission (2014) *Monitoring the Mental Health Act in 2012/13*, The Stationery Office.

Care Quality Commission (2018) Mental Health Act: Approved Mental Health Professionals Service, CQC.

Carson, G. (2018) 'Approved mental health professionals: pressures have never been greater' in *Community Care*, February 2018.

Centre for Mental Health (2019) Reforming the Mental Health Act. London: Centre for Mental Health

Care Quality Commission (2020) *Monitoring the Mental Health Act in 2018/19*, The Stationery Office.

Care Quality Commission (2022) *Monitoring the Mental Health Act in 2020/21* (Care Quality Commission, London)

Clark D, M. (2018) 'Realising the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program' in Annual Review Clinical Psychology. **7** (14)

Coar, L. and Sim, J. (2006) 'Interviewing One's Peers: Methodological Issues in a Study of Health Professionals' in *Scandinavian Journal of Primary Healthcare 2006 4*

Considine, T, Hollingdale, P. and Neville, R. (2015) 'Social Work, Pastoral Care and Resilience' in *Pastoral Care in Education* 33 (4)

Cooper, A. (2009) 'Hearing The Grass Grow: Emotional and Epistemological Challenges of Practice-Near Research' in *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*, 23 (4) 429-442

Cooper, K. (2021) *Deadly Delays: Mental Health Beds Supply* available at : Deadly delays: mental health beds supply (bma.org.uk)

Cruickshank, J. (2003) *Critical Realism: The Difference it Makes,* Routledge.

Dean, M. (2010) *Governmentality: Power and Rule in Modern Society*, Sage Publications.

Delamont, S, Atkinson, P. and Pugsley, L. (2010) 'The Concept Smacks of Magic: Fighting Familiarity Today' in *Teaching and Teacher Education*, **26** 3-10

Department for Education (2011) *Munro Report of Child Protection: Final Report – a Child Centred System*, Department for Education

Department of Health (1999) *Report of the Expert Committee: Review of the Mental Health Act 1983*, TSO, London.

Department of Health (2000*) White Paper: Reforming the Mental Health Act,* TSO, London.

Department of Health (2000b) *No Secrets: Guidance on Protecting Vulnerable Adults in Care*, The Stationary Office, London.

Department of Health & The Welsh Assembly (2008) *Guidance on Nominating a Consultee for Research involving adults who lack capacity to consent*, TSO, London.

Department of Health (2007) *Mental Capacity Act Code of Practice*, The Stationery Office

Department of Health (2008) Mental Health Act Code of Practice, The Stationery Office

Department of Health & The Welsh Assembly (2008) Guidance on Nominating a Consultee for Research involving adults who lack capacity to consent, TSO, London.

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 (CM 8735),* The Stationery Office, London.

Department of Health (2015) *Stronger Code: Better Care: Government Response to the Consultation on the Mental Health Act 1983 Code of Practice*, Department of Health, London.

Department of Health (2018) *Modernising the Mental Health Act Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983*, DHSC, London.

Department for Health and Social Care (2019) *National Workforce Plan for Approved Mental Health Professionals* (DHSC, London).

Department of Health and Social Care (2020) *The Coronavirus Act*, TSO.

Department for Health and Social Care (2021a) *The Approved Mental Health Professional Workforce in the Adult Social Care Sector,* DHSC.

Department of Health and Social Care (2021b) *Responding to Covid 19: The Ethical Framework for Adult Social Care*,

Department of Health and Social Care (2022a) *Draft Mental Health Bill*, DHSC.

Department of Health and Social Care (2022b) *Chief Social Workers Report 2021/22*, Department of Health and Social Care.

Department of Social Care (2022c) Keep Calm and Call an AMHP [available at: Keep calm and call an AMHP - Social work with adults (blog.gov.uk)]

Dwyer, S. (2011) 'Walking the Tightrope of a Mental Health Act assessment' in *Journal of Social Work Practice* **26** (3)

Eastman, N. and Peay, J. (1999) *Law Without Enforcement: Integrating Mental Health and Justice,* Bloomsbury Publications.

Economic and Social Research Council (2012) Framework for Research Ethics, ESRC (www.sddu.leeds.ac.uk/uploaded/www.esrc.ac.uk__images_Framework-for-Research-Ethics_tcm8-4586.pdf - 321k - 2012-10-26)

Eisenberg, L. (1988) 'The Social Construction of Mental Illness' in *Psychological* Medicine 18 1-9.

Evans, T. (2015) 'Using Evidence to Inform Decision Making' in Webber, M. (2015) (ed) *Applying Research Evidence in Social Work Practice*, Palgrave Macmillan.

Evans, T. and Harris, J. (2004) 'Street Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion' in *British Journal of Social Work*, 34 871-895.

Evans, T. and Hupe, P. (eds) (2019) *Discretion and the Quest for Controlled Freedom*, Palgrave Macmillan

Ferguson, H. (2009) 'Driven to Care: The Car, Automobility and Social Work' in *Mobilities* 4 (2)

Ferguson, H. (2010) 'Walks, Home Visits and Atmospheres: Risk and Everyday Practices and Mobilities of Social Work and Child Protection' in *British Journal of Social Work,* **40** 1100-1117.

Ferguson, H. (2011) *Child Protection Practice*, Palgrave Macmillan, Basingstoke.

Ferguson, H. (2014) 'What Social Workers do in Performing Child Protection Work: Evidence from Research into Face to Face Practice', in *Child and Family Social Work 21st March 2014, DOI: 10.1111/cfs.12142*

Ferguson, H. (2016) 'Professional helping as negotiation in motion: social work as work on the move' in Applied Mobilities 1 (2)

Ferguson, H (2020) 'Social work from home: Creating thinking spaces' in *Research in Practice*

Fistein, E,C, Clare, I,C,H, Redley, M. and Holland, A, J. (2016) 'Tensions Between policy and practice: A qualitative analysis of decisions regarding compulsory admission to psychiatric hospital' in *International Journal of Law Psychiatry* 46.

Fook, J. (2002): *Social Work: Critical Theory and Practice,* Sage Publications, London.

Fook, J. and Askeland, G, A. (2006) 'The 'Critical' in Critical Reflection in White, S, Fook, J. and Gardner, F. (2015) *Critical Reflection in Health and Social Care*, Open University Press, Berkshire.

Flyberg, B. (2006) 'Five Misunderstandings about Case-Study Research' in *Qualitative Enquiry,* 12 (2) 219-245.

Foucault, M. (ed) (1973) *I Pierre Riviere, having slaughtered my Mother, my Sister and my Brother: A Case of Patricide in the 19th Century*, University of Nebraska Press.

Foucault, M. (1988) 'The Ethic of the Care of the Self as a Practice of Freedom' in Bernauer, J. and Rasmussen, D. (eds) (1988) *The Final Foucault*, Cambridge, Massachusetts

Froggett, L. (2012) 'Practice-Near and Practice-Distant Methods in Human Services Research' in *Journal of Research Practice*, **8** 2.

Fulford, K, W, M. (2011) 'The Value of Evidence and Evidence of Values: bringing together values-based and evidence-based practice in policy and service development in mental health' in *Journal of Evaluation in Clinical Practice*,17 976-987

Furminger, E. and 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?' in *British Journal of Social Workers*, 39 901-917.

Gault, I. (2009) 'Service-user and carer perspectives on compliance and compulsory treatment in community mental health services' in *Health and Social Care in the Community* 17 (5) 504-513.

Gibbs, G. (1988) Learning by Doing: A Guide to teaching and learning methods, Further Education Unit, Oxford.

McFadden, P, Moriarty, J, Mallett, J, Schroder, H., Ravalier, J., Manthorpe, J., Currie, D., Nicholl, P., McGrory, S., & Neill, R. (2022) *Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic: Findings from a UK Survey. Phase 4: 24th November 2021 – 4th February 2022*. University of Ulster Press.

Glaser, B. and Strauss, AL, (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research,* Aldine Publishing Company.

Glover-Thomas, N. (2011) 'The Age of Risk: Risk Perception and Determination Following the Mental Health Act 2007' in *Medical Law Review* 19 581-605.

Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, Penguin Books, Chippenham.

Green, L, M. (ed) (2008) *The SAGE Encyclopedia of Qualitative Research*, SAGE Publications.

Greenberger, D. and C,A Padesky (1995) Mind over mood : a cognitive therapy treatment manual for clients, Guildford Press.

Gregor, C. (2010) 'Unconscious Aspects of Statutory Mental Health Social Work: Emotional Labour and The Approved Mental Health Professional' in *Journal of Social Work Practice* 24 (4) 429-443.

The Guardian Social Care Network (2013). *Social Workers: The Forgotten Emergency Service,* Guardian Social Care Network.

Hackett, S.A and Taylor, A. (2013) 'Decision Making in Social Work with Children and Families: The Use of Experiential and Analytical Cognitive Processes' in B*ritish Journal of Social Work Advance Access* (April 2013)

Hall, P. (2017) 'Mental Health Act Assessments – Professional Narratives on Alternatives to Hospital Admission' in *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community 31 4*

Hammersley, M. (2000) *Taking Sides in Social Research: Essays on Partisanship and Bias*, Routledge, Oxon.

Hammersley, M and Atkinson, P (2007) *Ethnography: Principles in Practice (3rd edn),* Routledge

Hardy, M (2015) 'Using Evidence to Inform assessments' in Webber, M. (ed) (2015) *Applying Research Evidence in Social Work Practice,* Macmillan Publishing.

Hargeaves, R. (2000) '*A Mere transporter – the legal role of the Approved Social Worker', Journal of Mental Health Law*, Vol. December 2000, 135-146.

Hargreaves,R. (2007) 'The Mental Health Bill 2006 – a social work perspective' in Journal of Mental Health Law, Vol: May 2007, 85-97.

Hatfield, B. (2008) 'Powers to Detain under the 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' in *British Journal of Social Work* 2008 38 1553-1571.

Health and Care Professions Council (2012) *Standards of Proficiency - Social Workers in England*, HCPC.

Heginbotham, C. and Elson, T. (1999) 'Public Policy via Law: Practitioner's Sword and Politician's Shield' in Eastman, N. and Peay, J. (1999) *Law Without Enforcement: Integrating Mental Health and Justice*, Hart Publishing, Oxford.

Hemmington, J, Graham,M, Marshall, A, Brammer, A, Stone, K. and Vicary, S. (2021) *Approved Mental Health Professionals, Best Interests Assessors and People with Lived Experience: An Exploration of Professional Identities*, Social Work England.

Hoge, S, K, Lidz, C, W, Eisenberg, M, Gardner, W, Monahan, J, Mulvey, E, Roth, L. and Bennett, N. (1997) 'Perceptions of Coercion in the Admission of Voluntary and Involuntary Psychiatric Patients' in International Journal of Law and Psychiatry, 20 (2) 167-181

House of Lords Paper 79-1 and the House of Commons Paper 95-1(2005) *Joint Committee on the Draft Mental Health Bill Volume II Oral and Written Evidence*, TSO, London.

House of Lords, House of Commons (2005) *Joint Parliamentary Committee on the Draft Mental Health Bill*, House of Lords Publications available online: Joint Committee on the Draft Mental Health Bill - First Report (parliament.uk)

Horwitz, A. (2012) *Social Constructions of Mental Illness*, Oxford University Press, Oxford.
Huda, A, S. (2019) *The Medical Model in Mental Health: An Explanation and Evaluation*, Oxford University Press.

HM Government (2014) *Mental Health Crisis Concordat: Improving Outcomes for People Experiencing Mental Health Crisis*, The Stationery Office

HM Government (2008) *Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008*

Houston, S. (2001) 'Beyond Social Constructionism: Critical Realism and Social Work' in *British Journal of Social Work* 31 6

Houston, S. (2010) 'Prising Open the Black Box: Critical Realism, Action Research and Social Work' in *Qualitative Social Work 9 (1)*

Houston, S. (2003) 'Moral Consciousness and decision-making in child and family social work' in *Adoption and Fostering* 27 (3) 61-7

Huda, A, S. (2019) *The Medical Model in Mental Health: An Explanation and Evaluation*, Oxford University Press, Oxford.

Hughes, E. C. (1971) *The Sociological Eye: Selected Papers*, Aldine-Atherton

Ingram, R. and Smith, M. (2018) *Relationship Based Practice: Emergent Themes in Social Work Literature*, IRISS.

Jobling, H. (2016) 'What counts as 'counter-conduct'? A governmental analysis of resistance in the face of compulsory community care' in *Social Policy Review*, 28.

Johns, C. (2000) '*Becoming a Reflective Practitioner: A Reflective and Holistic Approach to Clinical Nursing, Practice Development and Clinical Supervision*, Wiley-Blackwell.

Jones, J, Nolan, P, Bowers, L, Simpson, A, Whittington, R, Hackney, D. and Bhui, K. (2010) 'Psychiatric Wards: Places of Safety?' in *Journal of Psychiatric and Mental Health Nursing* 17 124-130.

Keown, P, Weich, S, Bhui, K S, Scott, J. (2011) 'Association between Provision of Mental Illness Beds and Rate of Involuntary Admissions in the NHS in England 1988-2008: An Ecological Study' in *BMJ* 2011 (343)

Kesslering, G. (2006) 'Pioneering mobilities: new patterns of movement and motility in a mobile world' in Environment and Planning 38

Kinney, M. (2009) 'Being Assessed under the 1983 Mental Health Act – Can it Ever Be Ethical? in *Ethics and Social Welfare* **3** (3)

Kinsella, E. A., & Pitman, A. (2012) Engaging phronesis: Professional practice and education. In A. Kinsella & A. Pitman (Eds.), *Phronesis as Professional Knowledge: Practical Wisdom in the Professions.* Rotterdam: Sense, pp. 1–12.

Knott, G., and K. Bannigan. (2013) "A Critical Review of the Approved Mental Health Professional Role and Occupational Therapy." *British Journal of Occupational Therapy* 76 (3)

Kohli R,K,S. and Dutton J. (2018) 'Working in complex, short-term relationships' in G Ruch, D Turney & A Ward (eds.) (2018) *Relationship-Based Social Work* (2nd edition), Jessica Kingsley

Laing, R, D. (1960) *The Divided Self: An Existential Study in Sanity and Madness*, Penguin, Harmondsworth.

Lawson, A. and Beckett, A, E. (2021) 'The Social and Human Rights Based models of Disability: Towards a Complementary Thesis' in *International Journal of Human Rights*, 25 2

Leah, C. 2019. "Approved Mental Health Professionals: A Jack of All Trades? Hybrid Professional Roles within a Mental Health Occupation." *Qualitative Social Work*

Leah, C. (2022) 'The Role of the Approved Mental Health Professional: A 'Fool's' Errand?' in *British Journal of Social Work* April 2022

Le Grand, J. (2010) 'Knights and Knaves Return: Public service Motivation and the Delivery of Public Services' in *International Public Management Journal*, 13 (1) 56-71.

Lester, H. and Glasby, J. (2006) *Mental Health Policy and Practice*, Palgrave, Basingstoke.

Lipsky, M. (1980) Street- Level Bureaucracy: Dilemmas of the Individual in Public Services Russell Sage Foundation.

Lipsky, M. (2010) *Street- Level Bureaucracy: Dilemmas of the Individual in Public Services (30th Anniversary Edition)*, Russell Sage Foundation.

Litz, B. T., Stein, N., Delany, E., et al. (2009) 'Moral injury and moral repair in war veterans: A preliminary model and intervention strategy' *Clinical Psychology Review*, 29(8), 695-706.

Longhofer, J. and Floersch, J. (2013) 'Values in a Science of Social Work: Values-Informed Research and Research-Informed Values' in *Research on Social Work* Practice 24 5

Lymbery, M. (2000) 'The Retreat from Professionalism: From Social Worker to Care Manager' in Malin, N (ed) (2000) *Professional Boundaries and the Workplace*, Routledge, London.

Maclean, S, Caffrey, B. (2020) Creating Online Reflective Spaces when Working from Home, Community Care Inform.

Mental Health Alliance (2004) Revised Mental Health Bill is Unfit for 21st Century, MHA, London.

McFadden, P., Gillen, P., Moriarty, J., Mallett, J., Schroder, H., Ravalier, J., Manthorpe, J., Currie, D., Nicholl, P., McGrory, S., & Neill, R. (2021) *Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic: Phase 3 10th May 2021-2nd July 2021: Findings from a UK Survey.* University of Ulster Press.

Miller, P. and Rose, N. (eds) (1986) The Power of Psychiatry, Polity Press, Oxford.

Morriss, L. 2016. "AMHP Work: Dirty or Prestigious? Dirty Work Designations and the Role of the Approved Mental Health Professional." *British Journal of Social Work* 46 (3): 703–718.

Morrison, A,P, Renton, J, C, French, P. and Bentall, R. (2008) *Think You're Crazy? Think Again: a Resource Book for Cognitive Therapy for Psychosis*, Routledge.

Murphy E, and Dingwall R. (2007) 'Informed consent, anticipatory regulation and ethnographic practice in *Social Science and Medicine* 65 (11)

NHS (2019) *The NHS Long Term Plan*, National Health Service.

NHS Digital (2022) *Mental Health Act statistics 2021/22* Mental Health Act Statistics, Annual Figures, 2021-22 - NDRS (digital.nhs.uk)

National Institute for Clinical Excellence (2015) *Psychosis and Schizophrenia in Adults: Quality Standards*, NICE.

National Service User Network (2021) Response to the Mental Health Act White Paper, NSUN available at Response to the MHA White Paper - NSUN website

Nyathi, N. (2018) 'Child protection decision-making: social workers' perceptions' in *Journal of Social Work Practice Psychotherapeutic Approaches in Health, Welfare and the Community* 32 2

O'Sullivan, T. (1999) *Decision Making in Social* Work (2nd edn), Palgrave Macmillan, Basingstoke.

Ortlipp, M. (2008) 'Keeping and Using Reflective Journals in the Qualitative Research Process', *The Qualitative Report*, 13 (4) 695-705

Parker, J. (2010) 'Approved Social Worker to Approved Mental Health Professional: evaluating the changes within education and training' in *The Journal of Mental Health Training, Education and Practice* 5 (2)

Patton, M, Q. (1990) *Qualitative Evaluation and Research Methods (2nd edn*), Sage Publications.

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*, Sage Publications, London.

Pawson, R, Boaz, A, Grayson, L. and Barnes, C. (2003) *Types and Quality of Knowledge*, Social Care Institute of Excellence.

Pawson, R. (2006) 'Digging for Nuggets: How 'Bad' Research can Yield 'Good' Evidence' in International Journal of Social Research Methodology, 9 (2)

Peay, J. (2003) *Decisions and Dilemmas: Working with Mental Health Law*, Bloomsbury Publishing.

Pease, B. (2012) 'Challenging the Dominant Paradigm: Social Work Research, Social Justice and Social Change' in Shaw, I, Briar-Lawson, K, Orme, J. and Ruckdeschel, R. (2012) *The Sage Handbook of Social Work Research, Sage Publications*, Basingstoke.

Pickett, K. and Wilkinson, R, G. (2009) *The Spirit Level: Why Equality is Better for Everyone,* Penguin Publications.

Pilgrim, D. (2014) 'Some implications of Critical Realism for Mental Health Research' in *Social Theory and Health 12 1*

Pilgrim,D. (2015) '"Mental Health Law' and 'Mental Health Policy' in the UK in Matthews, S, O'Hare, P. and Hemmington, J. (eds) (2015) *Approved Mental Health Practice: Essential Themes for Students and Practitioners,* Palgrave.

Pilgrim, D. and Rogers, A. (2010) *A Sociology of Mental Health and Illness (4th edn),* Open University Press.

Pilgrim, D. and Rogers, A. (2011) 'Danger and Diagnosed Mental Disorder' in Pilgrim, d, Rogers, A. and Pescosolio, B. (eds) *The SAGE Handbook of Mental Health and Illness*, SAGE Publications.

Pithouse, A. (1998) *Social Work: The Social Organisation of an Invisible Trade (2nd edn),* Ashgate, Aldershot.

Porter, R. (2002) Madness: A Brief History, Oxford University Press.

Postle, K, Beresford, P. and Hardy, S. (2008) 'Assessing Research and Involving People Using Health and Social Care Services: Addressing the Tensions' in *Evidence and Policy* 4 (3) 251-262.

Quirk, A, Lelliott, P.and Audini, B. (1999) Performing the Act: A Qualitative Study of the Process of Mental Health Act Assessment, Royal College of Psychiarists Research Unit, London.

Quirk, A, Lelliott, P, Audini, B. and Buston, K (2000) Performing the Act: A Qualitative Study of the Process of Mental Health Act Assessments: Final Report to the Department of Health, DofH.

Quirk, A, Lelliott, P, Audini, B. and Buston, K. (2003) 'Non-clinical and extra-legal influences on decisions about Compulsory Admission to Psychiatric Hospital' in Journal of Mental Health, 12 (2) 119-130

Ridley, J. (2014) 'The Experiences of Service Users' in Matthews, S, O'Hare, P. and Hemmington, J (eds) *Approved Mental Health Practice: Essential Themes for Students and Practitioners,* Palgrave, Basingstoke.

Ridley, J, Rosengard. A, Hunter, S. and Little, S. (2009) *Experiences of the Early Implementation of the Mental Health (Care and Treatment).(Scotland) Act 2003: A cohort Study, Scottish Government*, Edinburgh.

Romero-Garcia, M, Delgado-Hito, P, Gálvez-Herrer, M, Ángel-Sesmero, J, A. Velasco-Sanz,, T, R, Benito-Aracil L. and Heras-La Calle, G. (2022) 'Moral distress, emotional impact and coping in intensive care unit staff during the outbreak of COVID-19' in *Intensive Critical Care Nursing* (2022) 6

Romme, M. and Escher, S. (1993) *Accepting Voices*, MIND, London.

Rose, D, Fleischman, P. and Wykes, T. (2008) 'What are Mental Health Service Users' Priorities for Research in the UK?' in *Journal of Mental Health* 17 (5) 520-530

Rose, N. (1999) *Powers of Freedom: Reframing Political Thought*, Cambridge University Press.

Ruch, G, Turney, D. and Ward, A. (2018) *Relationship Based Practice: Getting to the Heart of Practice* (2nd edn) Jessica Kingsley Publishers.

Ruck-Keene, A. (2022) Draft Mental Health Bill now published – Mental Capacity Law and Policy

Russon, J. and Wallcraft, J. (2011) 'Resisting Variables – service user/survivor perspectives on researching coercion' in Kallert, T, W, Mezzich, J, E. and Monahan, J. (2011) *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects,* John Wiley & Sons Ltd.

Sabatier, P, A. and Jenkins-Smith (eds) (1993) *Policy Change and Learning: An Advocacy Coalition Approach*, Westview Press, Oxford.

Sayce, L. (2000) *From Psychiatric Patient to Citizen*, Palgrave, Basingstoke.
Patton, M, Q. (1990) *Qualitative Evaluation and Research Methods (2nd edn*), Sage Publications.

Szasz, T, S. (1974) *The Myth of Mental Illness*, Harper Collins, London.

Schon, D,A. (1983) *The Reflective Practitioner: How Professionals Think in Action*, The Perseus Books Group, USA.

Singer, J. Cummings, C, Moody, S.A and Benuto, L. T (2019) 'Reducing burnout, vicarious trauma, and secondary traumatic stress through investigating purpose in life in social workers' in Journal of Social Work **20** (5)

Simon, H. A. (1956) 'Rational choice and the structure of the environment' in *Psychological Review*, **63**(2)

Skills for Care (2021) *The Approved Mental Health Professional Workforce in the adult social care sector,* Skills for Care

Smith, M. S. (2015) "Only Connect', 'Nearest Relative's' Experiences of Mental Health Act Assessments' *Journal of Social Work Practice* **29** (3)

Smith, J. and Noble, H (2016) 'Reviewing the Literature' in *Evidence-Based Nursing* **19** (1)

Smith, J, A, Flowers, P, Larkin, M. (2022) *Interpretative Phenomenological Analysis: Theory, Method and Research (2nd edn)* Palgrave.

Social Work England (2020) Approved Mental Health Professions (AMHP) Course Guidance, Social Work England.

Spandler, H. (2014) 'The Problem of Psychiatric Diagnosis' in Matthews, S, O'Hare, P. and Hemmington, J (eds) *Approved Mental Health Practice: Essential Themes for Students and Practitioners,* Palgrave, Basingstoke.

Stevens, M., Martineau, S., Manthorpe, J., Steils, N. and Norrie, C. (2018) *Who wants to be an AMHP? London: Social Care Workforce Research Unit*, King's College London.

Stone, K. (2019) 'Approved Mental Health Professionals and Detention: An Exploration of Professional Differences and Similarities' in *Practice* 31 2

Stone, K, Vicary, S, Buckland, R. and Scott, C (2019) 'Ethical approval and being a virtuous social work researcher. The experience of multi-site research in UK health and social care: An approved mental health professional case study' in *Ethics and Social Welfare* 14 (2).

Szasz, T, S. (1974) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (Revised Edition),* Harper and Row Publishers, New York.

Taylor, C. and White, S. (2000) *Practising Reflexivity in Health and Welfare: Making Knowledge*, Open University Press, Buckingham.

Taylor, B. (2013) *Professional Decision Making and Risk in Social Work* (2nd edn) Learning Matters, SAGE Publications.

Taylor B (2017) 'Heuristics in professional judgement: a psycho-social rationality model' in *British Journal of Social Work, 47(4),*

Taylor, B. and Whittaker, A. (2018) 'Professional Judgement and Decision Making in Social Work' in *Journal of Social Work Practice Psychotherapeutic Approaches in Health, Welfare and the Community* 32 2

Tew, J. (2006) 'Understanding Power and Powerlessness: Towards a Framework for Emancipatory Practice in Social Work' in *Journal of Social Work* (2006) 6 (1)

Tew, J. (2011) *Social Approaches to Mental Distress*, Palgrave, Basingstoke.

Tew, J, Gould, N, Abankwa, D, Barnes, H, Beresford, P, Carr, S, Copperman, J, Ramon, S, Rose, D, Sweeney, A. and Woodward, L. (2006) *Values and Methodologies for Social Research in Mental Health*, Social Perspectives Network.

Tew, J, Slade, M, Bird, V, Melton, J. and Le Boutillier, C. (2011) 'Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence' in *British Journal of Social Work* (2011) 1-18

The College of Social Work (2013) *AMHP Community of Interest: AMHP Practice Survey 2013,* TCSW, London.

The College of Social Work (2014) T*he Role of the Social Worker in Adult Mental Health Services,* TCSW, London.

The Mental Health Act 1983, The Stationary Office, London.

The Schizophrenia Commission (2012) *The Abandoned Illness: A Report from the Schizophrenia Commission*, Rethink Mental Illness, London.

Teater, B., Devaney, J. and Forrester, D. (2017) *Quantitative research methods for social work: Making social work count*. Bloomsbury Publishing.

Vicary, S, Young, A. and Hicks, S. (2019) 'Role Over' or Roll Over? Dirty Work, Shift and Mental Health Act Assessments in *British Journal of Social Work* 2019 (49)

Vicary, S. (2020) '"Pull" The Active Use of Dissonance: An IPA Pearl to Show Emotion Management in Action' in *Practice: Social Work in Action*, 33 (4)

Wallcraft, J, Read, J. and Sweeney, A. (2003) *On our Terms: Users and survivors of mental health services working together for support and change*, The Sainsbury Centre for Mental Health

Watson, D. (2015) 'Becoming an Approved Mental Health Professional: an analysis of the factors that influence individuals to become Approved Mental Health Professionals' in *Journal of Mental Health* Early Online 1-5

Webber (2012) 'How the Latest Mental Health Act Research should inform Social Work Practice' in Community Care (August 2012)

(http://www.communitycare.co.uk/2012/08/30/how-the-latest-mental-health-act-research-should-inform-social-work-practice/)

Webber, M. and Hudson, J. (2012) *The National AMHP Survey 2012 Final Report: Stress and the Statutory Role, Is there a Difference between different Professional Groups?* Kings College. London.

Webber, M. and Carr, S. (2015) 'Applying Research Evidence in Social Work Practice: Seeing Beyond Paradigms' in Webber, M. (2015) (ed) *Applying Research Evidence in Social Work Practice*, Palgrave Macmillan.

Widdowson, MDJ (2011) 'Case Study Research Methodology' in *International Journal of Transactional Analysis Research* ***2*** *(1)*

Wilkinson, J. (2019) How does Critical Realism relate to Critical Theory? In Social Theory Applied available at How does critical realism relate to critical theory? - Social Theory Applied

Zubin, J. and Spring, B. (1977) 'Vulnerability: A New View on Schizophrenia' in *Journal of Abnormal Psychology* 86 103-126

APPENDIX 1:

Service User Feedback on Research Project Proposal: Individuals who have been assessed under the Mental Health Act

The draft documents for this research project I have shared so far with a total of **9** MH service users (including myself). **4** of which are trained Advocates (IMHA'S) working within a User led Organisation.

Feedback on Research Rational:

All the service users I approached for feedback felt that this Research proposal is a much needed piece of work. In particular the Advocates, who felt that it will help to flag up various issues around the pressure decision makers are currently under, for example risk issues(to the service provider – which often overrides the service users' views, wishes, feelings and involvement in any of the decision making) with 'informal' inpatients who wish to be discharged, (particularly in Older Peoples MH services), and the lack of beds for 'informal' inpatients – which the advocates in their work are often privy to; and have growing concerns around the increased practice of de facto detainment cases as a result of these pressures.(which could explain the increased usage of the MHA). Therefore there was a mutual agreement that this particular study along with the eventual findings would greatly benefit both individuals subject to the MHA assessment process and the decision makers themselves. (As a direct result of this opportunity to explore what the realities are and how practice could be improved).

Ethical Issues:

In general all of us agreed on the ethical framework for the proposal; although I was asked to raise a couple of concerns with Charlotte around the **consent to Interview** process. Service Users I spoke with felt that it may be unethical to offer participants a copy of the audio recording for the following reasons:

1. Participants may leave or accidently loose the recording in a public place.
2. Replaying the recording at a later date – may stir up unhelpful emotions.
3. Many of the Service Users I spoke to have experience of participating in Research and had never previously been offered a copy of the audio recording of their interview.

However people did say that if a participant **voluntarily** asked for a copy of their recording then that would be ok – providing Charlotte advised them of these possible risks.

We also had discussions around the proposed option of a participant's home being a venue for interview. The majority of us felt that that this option was a risk for both the

participant and the researcher, i.e. it may feel too intrusive for the participant, or conflict with lone working policy guidelines for Charlotte. Again no one out of the nine of us had ever experienced being interviewed in our own homes in any of our MH research activities; although some of us had experienced telephone interviews being undertaken within our own homes. Therefore we would like to suggest that all Interviews take place in a setting appropriate to the interview subject i.e. CMHT, University or hospital ward.

Another discussion we had was around the involvement of carers. Everyone agreed and felt that by involving carers in anyway within this particular research topic would possibly create conflicts of interest, and dilute the service user perspective – which along with the AMHP/Decision maker's perspective is what this piece of research is based upon.

If it is felt that a Carers perspective should be sought - then the general feeling from everybody was this would have to take place within a separate Research study – specific to capturing the carers view, so as to avoid any dilution and conflicting theories of the process experience for the individual who was being assessed.

I received some very positive feedback on the service user involvement elements of the research project, particularly around:

The invitation to the dissemination events.

A further suggestion here from service users that I spoke to would be for those participants who are willing, to maybe become involved in the planning of the dissemination events?

The invitation to Contribute to the Universities Healthcare Service User and Carer consultation group:

"Not only will the research project as a whole be beneficial to the MHA assessment process, it will also empower and encourage service users with their own personal development as well as 'have a voice' in future health research".

Research paper work for participants (service users).

I went through all the proposed paperwork with my service user colleagues, and we suggest one or two slight amendments i.e. consistency in wording, for easier reading/understanding etc. - where we saw fit from the service user perspective. For these please see accompanying documents.

XXXXXXXXX

Service User Liaison Worker/MH Advocate

07/11/14

APPENDIX 2

Interview Schedule – AMHP

(v2 16/11/14)

Introduction:

Thank you again for allowing me to observe you carry out your work. I'd like to ask you some questions about this assessment but the interview is designed to allow flexibility in what you tell me.

Please tell me a little about your background ie how long you've been an ASW/AMHP, your professional background (nurse etc) and when you first qualified.

Why did you decide to become an AMHP?

Looking back at the recent assessment, what are your overall impressions of what went on?

What went well?

What didn't go so well?

Would you have done anything differently with the benefit of time to reflect on what happened?

What types of knowledge did you draw upon during the assessment to help you make a decision?

(Prompts – tacit, case law knowledge, evidence based/research based knowledge)

The Code of Practice outlines a set of 'Guiding Principles' –this isn't a test but how did you put these into practice during the assessment?

If hesitancy…..prompt re whether these are incorporated into what they do or if they think about them afterwards.

Dependent upon the outcome of the assessment and reflective memos written by the researcher (To identify barriers and aids to decision making within the context of a Mental Health Act assessment – such as the impact of time constraints, emotion and environment on decision making):

- I noticed this, please tell me more about that
- How did you manage (an adverse incident, issues with conveyance, accessing a bed, risk issues)
- Reflections on the time of day of the assessment eg out of hours, on a Monday, on a Friday night. Prompts re the emotional impact of the assessment.

Thinking about AMHP practice in general, how and in what ways has carrying out the role changed since you first qualified.

What do you see as the main challenges for the role?

What do you see as the benefits of the role?

What other comments what would like to make about AMHP practice in general that we haven't had chance to talk about already?

Thank you for your time etc….

APPENDIX 3:

Interview Schedule – Service User

(V3 28/04/15)

Introduction

Thank you for agreeing to be interviewed by me today. The aim of this interview is for me to learn more about your experience of being assessed under the Mental Health Act recently as there is not a lot of research that has looked at this in detail before. Please tell me as little or as much as you feel able and if you need a break at any time, just say.

- Please tell me a little bit of background as to why you are, how long you have had contact with MH services etc.
- What do you remember about your recent assessment under the Mental Health Act?
- What are your main thoughts about that day?
- Why do you think you were assessed under the Mental Health Act?
- ***How were you involved in the decision making during the assessment?***
- ***How were your views and wishes taken into account?***
- What do you think about the outcome of the assessment?
- How could the experience have been improved for you?
- Although I appreciate that it is a difficult situation to be in, was there anything about the assessment that you felt went well?
- (If detained) What do you think might have helped avoid admission under the Act on that day?
- (If admitted but not detained) What helped you decide to be admitted to hospital voluntarily?

- (If not detained and not admitted voluntarily) What helped avoid admission to hospital on that day?
- What else would you like to say about your experience of being assessed that you think might help mental health practitioners improve their understanding of what it is like to be assessed under the Mental Health Act?
- Please tell me anything else that you think is important for me to know about your recent experience.

APPENDIX 4:

Participant Information Sheet – Approved Mental Health Professionals (V6 26/05/15)

Research Title: How do Approved Mental Health Professionals make Decisions During Mental Health Act Assessments?

Study Number: 15/IEC08/0024

Thank you for taking the time to read this information about the above research project. Before you decide whether to take part, it is important that you understand why the research is being done and what it will involve for you. Please read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the Study?

The focus of this research is on developing a more complete understanding of how decisions are made by Approved Mental Health Professionals (AMHPS) during Mental Health Act assessments.

Why have I been invited?

This research study aims to recruit up to 10 AMHP's who are currently carrying out AMHP duties on the xxxxxxxx AMHP duty rota.

Do I have to take part?

It is up to you to decide to take part in the research. The researcher Charlotte Scott will describe the study and go through this information sheet with you. If you agree to take part, she will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

If you agree to take part, Charlotte Scott will:

1. Arrange to observe you in practice on up to three of your AMHP duty days and observe any Mental Health Act assessments that you carry out on these days, subject to you making a decision that it is appropriate for her to be there. Field notes will be taken from the time the referral for the Mental Health Act assessment is received to capture research data about how you coordinate the assessment and gather information to help you make your decision on the outcome of the assessment. An audio recording will be made of the interview with the person being assessed if you and all other parties including the person being assessed, agree that this is appropriate.

2. You will also be invited to take part in an interview about your experiences of carrying out each assessment, reflecting on the decision making process and any issues that arose during the course of this piece of work. These interviews will be carried out by Charlotte Scott and will take around 1 hour. The interviews will be audio recorded, with your permission although you can also choose not to have them recorded in this way. They will be arranged at a time, date and location convenient to you and you can decide how many times you wish to be interviewed given the demands that this may place upon your time.

What will happen if I don't want to carry on with the study?

You are free to withdraw your consent to participate at any time including during an observation of your practice.

As an AMHP herself, Charlotte Scott will use her own professional judgement to stop the observation if necessary, for example if her presence seemed to be causing undue distress or there were any significant risk issues that she was contributing to. Charlotte will also withdraw from the observation if you or another member of the assessing team ask her to.

Will my taking part in this Research be kept confidential?

Any information you give to Charlotte will be kept confidential and secure, in line with the Data Protection Act 1998 with no identifying data stored with the notes. However, as duty of care as a researcher, and as a registered member of the Health Care Professionals Council, if you do tell Charlotte something that suggests malpractice or raises a safeguarding issue Charlotte is required to inform your line manager. You would be made aware if she planned to do this. Any information and data that is gathered as a result of your participation will only be used for the purposes of research. Charlotte will ensure that any views and comments you make during the interview will be anonymised in the final research report, to protect your confidentiality.

What are the benefits and risks of taking part?

Whilst there are no immediate benefits to taking part, the research aims to shed light on AMHP practice in the current context and contribute to a body of knowledge that seeks to identify issues for best practice and a clearer understanding of the experiences of those who are assessed under the Mental Health Act. By taking part in the research you would be contributing to this aim. This is an open process that seeks to shed more light on the realities of AMHP practice and decision making. There are minimal anticipated risks to taking part.

What will happen to the results of this research?

The findings will be initially written up into a doctoral thesis and then disseminated to a wide range of audiences in a variety of formats – academic journals, service user group feedback, practitioners and policy makers. The College of Social Work have a particular interest in the role of the AMHP and Mental Health Social Work and the findings will be shared with them. If you provide an email address to Charlotte Scott she will ensure you are kept informed of the research findings and invited to attend dissemination events as appropriate.

Who is organising and funding the research?

The research is funded via an Economic and Social Research Council Studentship to promote Social Work research. This research will be carried out by Charlotte Scott, whose background is as a Social Worker and Approved Mental Health

Professional (AMHP), but who is carrying out the research as a doctoral student at the School of Healthcare, University of Leeds.

Who has reviewed the research?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers. It has also been approved by the Research and Development Unit at xxxxx NHS and xxxx Council.

Who should I contact if I require further information?

For any further information please contact Charlotte Scott via email:
The supervisors for this project are: Redacted

Any complaints or concerns about the research should be sent to:
Redacted

APPENDIX 5:

School of Healthcare

UNIVERSITY OF LEEDS

Participant Information Sheet – Approved Mental Health Professional Co-Workers (V4 26/05/15)

Research Title: How do Approved Mental Health Professionals make Decisions During Mental Health Act Assessments?

Study Number: 15/IEC08/0024

Thank you for your interest in taking part in this Research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it will involve for you. Please read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the Study?

The focus of this research is on developing a more complete understanding of how decisions are made by Approved Mental Health Professionals (AMHPS) during Mental Health Act assessments..

Why have I been invited?

This research study aims to recruit up to 10 AMHP's who are currently carrying out AMHP duties on the xxxx duty rota. You are receiving this information as one of your AMHP colleagues has consented to be part of this research project.

Do I have to take part?

It is up to you to decide to take part in the research. The researcher Charlotte Scott will describe the study and go through this information sheet with you. If you agree to

take part, she will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

Your role is not the focus of the research but it may be that you have a conversation with the AMHP who is participating, for example when passing on information as part of a Mental Health Act assessment referral. You may also be part of the assessing team during the Mental Health Act assessment. Research notes will be taken from the time a referral for a Mental Health Act assessment is received by the participating AMHP and, if you and all the involved parties agree, an audio recording will be taken during the observations of the AMHP's interview with the person being assessed and so any comments that you make may be referred to in the context of this data collection process.

What will happen if I don't want to carry on with the study?

You are free to withdraw your consent to participate at any time including during an observation of your practice. This would mean that Charlotte would not include any of your comments in the research.

Will my taking part in this Research be kept confidential?

Any information you give to Charlotte will be kept confidential and secure, in line with the Data Protection Act 1998 with no identifying data stored with the notes. However, as duty of care as a researcher, and as a registered member of the Health Care Professionals Council, if you do tell Charlotte something that suggests malpractice or raises a safeguarding issue Charlotte is required to inform your line manager. You would be made aware if she planned to do this. Any information and data that is gathered as a result of your participation will only be used for the purposes of research. Charlotte will ensure that any views and comments you make during the interview will be anonymised in the final research report, to protect your confidentiality.

What are the benefits and risks of taking part?

Whilst there are no immediate benefits to taking part, the research aims to shed light on AMHP practice in the current context and contribute to a body of knowledge that seeks to identify issues for best practice and a clearer understanding of the experiences of those who are assessed under the Mental Health Act. By taking part in the research you would be contributing to this aim. This is an open process that seeks to shed more light on the realities of AMHP practice and decision making. There are minimal anticipated risks to taking part.

What will happen to the results of this research?

The findings will be initially written up into a doctoral thesis and then disseminated to a wide range of audiences in a variety of formats – academic journals, service user group feedback, practitioners and policy makers. The College of Social Work have a particular interest in the role of the AMHP and Mental Health Social Work and the findings will be shared with them. If you provide an email address to Charlotte Scott she will ensure you are kept informed of the research findings and invited to attend dissemination events as appropriate.

Who is organising and funding the research?

The research is funded via an Economic and Social Research Council Studentship to promote Social Work research. This research will be carried out by Charlotte Scott, whose background is as a Social Worker and Approved Mental Health Professional (AMHP), but who is carrying out the research as a doctoral student at the School of Healthcare, University of Leeds.

Who has reviewed the research?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers. It has also been approved by the Research and Development Unit at xxxxxx NHS Foundation Trust and xxxxx Council.

Who should I contact if I require further information?

For any further information please contact Charlotte Scott via email: Redacted

Supervisor contact details: redacted

Any complaints or concerns about the research should be sent to: Redacted

APPENDIX 6:

School of Healthcare

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Participant Information Sheet: Individuals who are due to be assessed under the Mental Health Act (V2 26/05/15)

Research Title: How do Approved Mental Health Professionals make Decisions During Mental Health Act Assessments?

Study Number: 15/IEC08/0024

Thank you for your interest in taking part in this research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it will involve for you. Please read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the Study?

The focus of this research is on developing a more complete understanding of how decisions are made by Approved Mental Health Professionals (AMHPS) during Mental Health Act assessments.

Why have I been invited?

You are being invited to participate in the study as an Approved Mental Health Professional who is also participating in the study has received a referral to carry out your upcoming assessment under the Mental Health Act. The researcher Charlotte Scott is observing their work to learn more about how AMHP's make decisions and would like to observe your assessment as part of this process. We would also like to learn more about your experience of being assessed.

Do I have to take part?

It is up to you to decide to take part in the research. The researcher Charlotte Scott will describe the study and go through this information sheet with you after you have had at least 48 hours to decide. If you agree to take part, she will ask you to sign a consent form.

What will happen to me if I take part?

There are two stages to the research that we would ask you to consider taking part in:

1. An observation of your Mental Health Act assessment.
   If you decide to take part the researcher Charlotte Scott will attend your Mental Health Act assessment to observe what happens. You can decide whether you agree to this being audio recorded or if you would prefer notes to be taken.

1. Taking part in a short interview (up to one hour) a few weeks after your assessment to talk about your experience of being assessed so that we can learn more about your views and include these in the research findings . This will be audio recorded, with your permission, to ensure that what you say is accurately reported, although you can choose for it not to be audio recorded if you prefer. Charlotte will aim to carry out this interview at an NHS site that is convenient to you.

What will happen if I don't want to carry on with the study?

You are free to withdraw your consent to participate at any time including during the observation of your assessment by asking Charlotte to leave. This will not affect your care in any way.

After the assessment takes place Charlotte Scott will contact you a short time afterwards to check that you still consent for her to use the information she gathered during your assessment. If you decide that you do not want the notes/audio recording transcript taken during your assessment to be used in the research project then your

decision will be respected and all information taken by Charlotte during your Mental Health Act assessment will be destroyed.

You can opt to consent only to the notes and audio recording of your assessment being used in the research if you decide that you do not want to take part in an interview.

If you decide to take part in an interview then you can also stop this at any time and withdraw your consent to participate in the research.

Will my taking part in this Research be kept confidential?

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else. Any information and data that is gathered as a result of your participation will only be used for the purposes of research. Charlotte will ensure that any views and comments you make during the interview will be anonymised in the final research report, to protect your confidentiality.

What are the benefits and risks of taking part?

While there are no immediate benefits in taking part, this piece of research hopes to learn more about, and gain valuable information around best practice, for the person being assessed. It aims to take into account the views, wishes and feelings of people who have been assessed under the Mental Health Act and learn more about how involved they are in the decision making during the assessment. It is important to gather views from a range of perspectives and as you were the person being assessed you have the best understanding of what that feels like. Gathering this information may help AMHP's and other mental health workers to inform their practice by taking into account the views of the people they assess.

You can also opt in to attending an information session at the University of Leeds, School of Healthcare to learn more about the Service User and Carer Involvement advisory group who are involved in deciding future areas of research. You will also

be given information about the Service User Network local to you and ways that you can contribute to this.

One possible risk of taking part if you consent to be interviewed by Charlotte is that you may find talking about your assessment difficult or distressing. You can take a break from the interview at any time and only have to talk about what you feel comfortable disclosing. If you would prefer you can ask a supporting person to attend with you. Your care coordinator will also be made aware that you have been asked to participate in the research and so you may find it helpful to talk to them after the interview if you require any support.

What will happen to the results of this research?

The findings will be shared with a wide range of audiences – academic journals, service user groups, practitioners and policy makers, an open process that seeks to shed more light on the realities of AMHP practice and decision making and the views of the people who have been assessed.

Who will be carrying out the Research?

This research will be carried out by Charlotte Scott, whose background is as a Social Worker and Approved Mental Health Professional (AMHP), but who is carrying out the research as a doctoral student at the School of Healthcare, University of Leeds. The research is funded via an Economic and Social Research Council Studentship to promote Social Work research.

Who has reviewed the research?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers. It has also been approved by the Research and Development Unit at XXXX NHS and xxxx Council.

What will happen to the results of this research?

The findings will be initially written up into a doctoral thesis and then disseminated to a wide range of audiences in a variety of formats. If you provide an email address to

Charlotte Scott she will ensure you are kept informed of the research findings and invited to attend dissemination events as appropriate.

Payment and Expenses? As a token thank you for your participation in either part of the research you will receive a £20 High Street voucher. In addition, any travel costs incurred as a result of your participation will be reimbursed.

Who should I contact if I require further information? If you would like any further information or have any questions either before or after your participation then please contact Charlotte Scott:

Either by: (CONTACT DETAILS FOR RESEARCHER AND SUPERVISORS REDACTED)

Any complaints or concerns about the research should be sent to: Redacted

Thank for taking the time to read this leaflet. Your views and experiences are at the core of the work that mental health workers do and therefore your input will be greatly valued.

APPENDIX 7:

School of Healthcare

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Participant Information Sheet: Individuals who have been assessed under the Mental Health Act (V4 26/05/15)

Research Title: How do Approved Mental Health Professionals make Decisions During Mental Health Act Assessments?

Study Number: 15/IEC08/0024

Thank you for your interest in taking part in this research study and for allowing the researcher Charlotte Scott to observe your recent Mental Health Act Assessment. Before you decide whether to consent to the use of the information that was gathered during that observation to be used in the research it is important that you understand why the research is being done and what it will involve for you. Please read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the Study?

The focus of this research is on developing a more complete understanding of how decisions are made by Approved Mental Health Professionals (AMHPS) during Mental Health Act assessments.

Why have I been invited?

You are being invited to participate in the study as an Approved Mental Health Professional who is also participating in the study received a referral to carry out your assessment under the Mental Health Act. The researcher Charlotte Scott is observing their work to learn more about how AMHP's make decisions. We would also like to learn more about your experience of being assessed.

Do I have to take part?

It is up to you to decide to take part in the research. The researcher Charlotte Scott will describe the study and go through this information sheet with you after you have had at least 48 hours to decide. If you agree to take part, she will ask you to sign a consent form.

What will happen to me if I take part?

There are two stages to the research that we would ask you to consider taking part in:

1. The use of the information gathered during your recent Mental Health Act assessment. If the assessment was audio recorded this will include a transcription of what happened or the use of notes if you chose not to agree to the audio recording.

2. Taking part in a short interview with Charlotte Scott (up to 1 hour) to talk about your experience of being assessed so that we can learn more about your views and include these in the research findings. This will be audio recorded, with your permission, to ensure that what you say is accurately reported, although you can choose for it not to be audio recorded if you prefer. Charlotte will aim to carry out this interview at an NHS site that is convenient to you.

What will happen if I don't want to carry on with the study?

You are free to withdraw your consent to participate at any time. Your care will not be affected in any way.

If you decide that you do not want the notes/audio recording transcript taken during your assessment to be used in the research project then your decision will be respected and all information taken by Charlotte during your Mental Health Act assessment will be destroyed.

You can opt to consent only to the notes and audio recording of your assessment being used in the research if you decide that you do not want to take part in an interview.

If you decide to take part in an interview then you can also stop this at any time and withdraw your consent to participate in the research.

Will my taking part in this Research be kept confidential?

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else. Any information and data that is gathered as a result of your participation will only be used for the purposes of research. Charlotte will ensure that any views and comments you make during the interview will be anonymised in the final research report, to protect your confidentiality.

What are the benefits and risks of taking part?

While there are no immediate benefits in taking part, this piece of research hopes to learn more about, and gain valuable information around best practice, for the person being assessed. It aims to take into account the views, wishes and feelings of people who have been assessed under the Mental Health Act and learn more about how involved they are in the decision making during the assessment. It is important to gather views from a range of perspectives and as you were the person being assessed you have the best understanding of what that feels like. Gathering this information may help AMHP's and other mental health workers to inform their practice by taking into account the views of the people they assess.

You can also opt in to attending an information session at the University of Leeds, School of Healthcare to learn more about the Service User and Carer Involvement advisory group who are involved in deciding future areas of research. You will also be given information about the Service User Network local to you and ways that you can contribute to this.

One possible risk of taking part if you consent to be interviewed by Charlotte is that you may find talking about your assessment difficult or distressing. You can take a break from the interview at any time and only have to talk about what you feel comfortable disclosing. If you would prefer you can ask a supporting person to attend with you. Your care coordinator will also be made aware that you have been asked to participate in the research and so you may find it helpful to talk to them after the interview if you require any support.

What will happen to the results of this research?

The findings will be shared with a wide range of audiences – academic journals, service user groups, practitioners and policy makers, an open process that seeks to shed more light on the realities of AMHP practice and decision making and the views of the people who have been assessed.

Who will be carrying out the Research?

This research will be carried out by Charlotte Scott, whose background is as a Social Worker and Approved Mental Health Professional (AMHP), but who is carrying out the research as a doctoral student at the School of Healthcare, University of Leeds. The research is funded via an Economic and Social Research Council Studentship to promote Social Work research.

Who has reviewed the research?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers. It has also been approved by the Research and Development Unit at XXXXNHS and XXXX Council.

What will happen to the results of this research?

The findings will be initially written up into a doctoral thesis and then disseminated to a wide range of audiences in a variety of formats. If you provide an email address to Charlotte Scott she will ensure you are kept informed of the research findings and invited to attend dissemination events as appropriate.

Payment and Expenses? As a token thank you for your participation in either part of the research you will receive a £20 High Street voucher. In addition, any travel costs incurred as a result of your participation will be reimbursed.

Who should I contact if I require further information? If you would like any further information or have any questions either before or after your participation then please contact Charlotte Scott:

Either by:
Or by Post:
Charlotte Scott (Post Graduate Research Student)

The supervisors for this project are:

Any complaints or concerns about the research should be sent to:

Faculty Head of Research and Innovation Support,

Thank for taking the time to read this leaflet. Your views and experiences are at the core of the work that mental health workers do and therefore your input will be greatly valued.

APPENDIX 8:

School of Healthcare

UNIVERSITY OF LEEDS

Participant Information Sheet: Individuals who have been assessed under the Mental Health Act but who chose not to be observed by the researcher (V3 24/06/15)

Research Title: How do Approved Mental Health Professionals make Decisions During Mental Health Act Assessments?

Study Number: 15/IEC08/0024

Thank you for taking the time to read this leaflet. Before you decide whether to take part, it is important that you understand why the research is being done and what it will involve for you. Please read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the Study?

The focus of this research is on developing a more complete understanding of how decisions are made by Approved Mental Health Professionals (AMHPS) during Mental Health Act assessments.

Why have I been invited?

You are being invited as the Approved Mental Health Professional who carried out your recent Mental Health Act assessment is participating in a research study. The researcher Charlotte Scott is observing their work to learn more about how AMHP's make decisions and information that relates to you was discussed as part of this. We would also like to learn more about your experience of being assessed.

Do I have to take part?

It is up to you to decide to take part in the research. The researcher Charlotte Scott will describe the study and go through this information sheet with you after you have had at least 48 hours to decide. If you agree to take part, she will meet with you to answer any further questions and ask you to sign a consent form.

What will happen to me if I take part?

There are two stages to the research that we would ask you to consider taking part in:

1 Before your recent Mental Health Act assessment the researcher Charlotte Scott observed the AMHP and made notes about the work that they carried out before they met with you. Although you chose not to have your assessment observed by the researcher we would like to ask you to consider allowing the information that was gathered before your assessment to be used in the research.

2 We would also like you to consider taking part in a short interview with Charlotte Scott (up to 1 hour) to talk about your experience of being assessed so that we can learn more about your views and include these in the research findings. This would be audio recorded, with your permission, to ensure that what you say is accurately reported, although you can choose for it not to be audio recorded if you prefer. Charlotte will aim to carry out this interview at an NHS site that is convenient to you.

What will happen if I don't want to carry on with the study?

You are free to withdraw your consent to participate at any time. This will not affect your care in any way.

If you decide that you do not want the notes taken prior to your assessment to be used in the research project then your decision will be respected and all information taken by Charlotte during your Mental Health Act assessment will be destroyed.

You can opt to consent only to the notes taken prior to your assessment being used in the research if you decide that you do not want to take part in an interview.

If you decide to take part in an interview in the weeks after your assessment then you can also stop this at any time and withdraw your consent to participate in the research.

Will my taking part in this Research be kept confidential?

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else. Any information and data that is gathered as a result of your participation will only be used for the purposes of research. Charlotte will ensure that any views and comments you make during the interview will be anonymised in the final research report, to protect your confidentiality.

What are the benefits and risks of taking part?

While there are no immediate benefits in taking part, this piece of research hopes to learn more about, and gain valuable information around best practice, for the person being assessed. It aims to take into account the views, wishes and feelings of people who have been assessed under the Mental Health Act and learn more about how involved they are in the decision making during the assessment. It is important to gather views from a range of perspectives and as you were the person being assessed you have the best understanding of what that feels like. Gathering this information may help AMHP's and other mental health workers to inform their practice by taking into account the views of the people they assess.

You can also opt in to attending an information session at the University of Leeds, School of Healthcare to learn more about the Service User and Carer Involvement advisory group who are involved in deciding future areas of research. You will also be given information about the Service User Network local to you and ways that you can contribute to this.

One possible risk of taking part if you consent to be interviewed by Charlotte is that you may find talking about your assessment difficult or distressing. You can take a break from the interview at any time and only have to talk about what you feel comfortable disclosing. If you would prefer you can ask a supporting person to attend with you. Your care coordinator will also be made aware that you have been asked to participate in the research and so you may find it helpful to talk to them after the interview if you require any support.

Who will be carrying out the Research?

This research will be carried out by Charlotte Scott, whose background is as a Social Worker and Approved Mental Health Professional (AMHP), but who is carrying out the research as a doctoral student at the School of Healthcare, University of Leeds. The research is funded via an Economic and Social Research Council Studentship to promote Social Work research.

Who has reviewed the research?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers. It has also been approved by the Research and Development Unit at xxxx NHS Trust and xxx Council.

What will happen to the results of this research?

The findings will be initially written up into a doctoral thesis and then disseminated to a wide range of audiences in a variety of formats. If you provide an email address to Charlotte Scott she will ensure you are kept informed of the research findings and invited to attend dissemination events as appropriate.

Payment and Expenses? As a token thank you for your participation in either part of the research you will receive a £20 High Street voucher. In addition, any travel costs incurred as a result of your participation will be reimbursed.

Who should I contact if I require further information? If you would like any further information or have any questions either before or after your participation then please contact Charlotte Scott:

Either by:

Email

Or by Post:

Charlotte Scott (Post Graduate Research Student)

The supervisors for this project are:

Any complaints or concerns about the research should be sent to:

Faculty Head of Research and Innovation Support,

Thank for taking the time to read this leaflet. Your views and experiences are at the core of the work that mental health workers do and therefore your input will be greatly valued.

APPENDIX 9

Information for person who has been assessed under the Mental Health Act (V1 03/01/15)

Thank you for allowing me to observe your Mental Health Act Assessment today.

My name is Charlotte Scott and I am a post graduate research student at the University of Leeds, School of Healthcare. I am carrying out this research to understand more about how Approved Mental Health Professionals make decisions during Mental Health Act assessments.

This research has been approved by the ….. Research Ethics Committee.

I will contact you again in the next few weeks to explain the research in more detail and to ask you to consider consenting to me using the information that I gathered today, in the research. Until I have checked this with you I will keep your information safe and confidential and not use it for the purposes of research unless you agree that I can.

If you have any questions in the meantime I can be contacted via email: or telephone: Please note that I am not at my desk on a regular basis but will return your call as soon as I am able.