Faculty of Health and Social Sciences

An Appreciative Inquiry into Approved Mental Health Professional decision-making at the point of referral for a Mental Health Act assessment

Thesis

(for Doctor of Philosophy)

Matthew Paul Simpson

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Abstract

Matthew Paul Simpson

An Appreciative Inquiry into Approved Mental Health Professional decision-making at the point of referral for a Mental Health Act assessment

In England and Wales, the Mental Health Act (MHA) 1983 provides a legal framework for psychiatric detention, requiring two medical recommendations from legally defined doctors, and an application from an Approved Mental Health Professional (AMHP). Civil detentions are the result of an assessment process involving all three professionals, not always together. AMHPs make detention decisions but they also make a decision at the point of referral. This qualitative study focused on that early decision made by AMHPs.

Nine AMHPs in one local authority attended four workshops exploring their experience of decision-making at the point of referral for an MHA assessment. The collaborative strengths-based methodology of appreciative inquiry encouraged participants to define the best of their practice, then build on those strengths with service design amendments. Data analysis was completed by participants within the workshops using nominal group technique.

At the point of referral for an MHA assessment participants were optimistic about avoiding detention, *changing gears* through the analysis and deconstruction of presented risks, and *buying time* to meet with the person referred and work in a more collaborative, transparent, and person-centred way. Based on my review of the available literature, these qualities are more challenging to achieve in traditional assessment approaches involving three professionals. As such this study highlights how AMHPs are more likely to achieve practice consistent with their values at the point of referral for an MHA assessment. The detention decision was in essence relocated to the assessment completed at the point of referral, and participants wanted to see this early decision valued within the service, creating a *triage AMHP* role and *AMHP s 13.1 report* to legitimise interventions that seek to avoid the necessity of an assessment process involving doctors. Participants also wanted a shared *pathway to assessment with doctors* seeking alternatives to detention, promoting a multi-agency emphasis on less restriction. This is the first study to explore this area of practice, and the rich understanding gained validates the importance of service structures that support this decision, enabling AMHPs to practise in a way that is consistent with their purpose and values.

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This doctorate has taken me five years to complete, requiring an investment of both time and money. Many a weekend have passed with my partner Sarah and daughter Lily accepting my absence from the fun they were having, and these are times we can't recover. Thank you Sarah and Lily for your understanding and your support.

Author's Declaration

I, Matthew Simpson

Declare that the upgrade thesis entitled 'An Appreciative Inquiry into Approved Mental Health Professional decision-making at the point of referral for a Mental Health Act assessment' and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

this work was done wholly while in candidature for a research degree at this University;

no part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution;

where I have consulted the published work of others, this is always clearly attributed;

where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

I have acknowledged all main sources of help;

Chapter three of this thesis is derived in part from my article published in Practice (Simpson 2020), available at www.tandonfonline.com/doi:10.1080/09503153.2020.1782874

Signed:

Date: 29th November 2022.

Glossary

AI	Appreciative Inquiry: A research methodology that is collaborative and focussed on strengths, the aim of which being to develop the organisation, service, or practice at the heart of the study.
AMHP	Approved Mental Health Professional: A role under the Mental Health Act 1983 in England and Wales, amended from ASW by the Mental Health Act 2007.
ASW	Approved Social Worker: A role under the Mental Health Act 1983 in England and Wales, amended to AMHP by the Mental Health Act 2007.
DHSC	Department of Health and Social Care: A ministerial department advising the government in England and some non-devolved matters in Wales, Scotland, and Northern Ireland. Renamed in 2018 from the DoH.
DoH	Department of Health: A ministerial department advising the government in England and some non-devolved matters in Wales, Scotland, and Northern Ireland. Renamed in 2018 to the DHSC.
MCA	Mental Capacity Act 2005: Legislation in England and Wales to make provision for those who lack capacity.
MHA	Mental Health Act 1983: Legislation in England and Wales concerning those with mental disorders.
NHS	National Health Service: The government funded health service in the United Kingdom.
s	Section: The main body of legislation is divided into sections and subsections.
SWE	Social Work England: The regulatory body for Social Workers in England.

Chapter 1 Introduction

1.1 The experience of interest

Chairing the current review of the Mental Health Act (MHA) 1983 in England and Wales Sir Simon Wessely drew attention to two-hundred years of society trying to balance individual autonomy with protecting its most vulnerable citizens (Department of Health and Social Care (DHSC), 2018). The result in England and Wales is currently the MHA 1983, which legitimises enforced psychiatric inpatient treatment. The MHA 1983 was amended in 2007 but references to it in this thesis will cite the original Act unless otherwise specified. The civil elements of this legislation are enacted by Approved Mental Health Professionals (AMHPs) (formerly Approved Social Workers under the original MHA 1983), who are responsible for making applications to detain people in hospital, even when this may be against their will, under certain circumstances and subject to two medical recommendations. Applications for detention are generally made following an MHA assessment. Such an assessment usually involves two doctors as defined under s 12 MHA 1983: a doctor with previous acquaintance if possible; a doctor approved under s 12(2) MHA 1983 with specialist knowledge in treating mental disorder, two s 12(2) approved doctors if the former doctor with previous acquaintance cannot be achieved. These two doctors and an AMHP all interview (to use the MHA 1983 term) the person, though not necessarily together. Each professional reaches an independent decision and all three must agree if the person is to be detained. The doctors involved make medical recommendations subject to a set of criteria defined in s 2(2) or s 3(2) MHA 1983 and based on their own professional judgement. The AMHP if provided with two medical recommendations makes a wider decision about whether detention is required “in all the circumstances of the case” (MHA 1983, s 13(2)). The assessment process is co-ordinated by the AMHP (Department of Health (DoH) 2015, chapter 14.41), who in the first instance receives some contact from a third party either to directly request an MHA assessment or to discuss a situation they believe may require such an assessment. Usually this third party is a professional, whether a GP or more commonly a mental health professional, though family members also often make requests. Sometimes the referral is made with little understanding of the current issues for the person referred (such as where the person will not willingly discuss their situation with the person referring), while at other times the referrer may have a detailed understanding of the person they are referring based on their relationship with that person

(such as where the person referring is working closely with the person they are referring). This thesis is concerned with AMHP decision-making at this stage.

Referrals to AMHPs are usually made on the basis that the referrer believes the person being referred requires detention in hospital due to their mental health. I explore further in my literature review about the pressure to detain at this point (Abbott 2018; Rooke 2020; Brammer 2020), with an emphasis on risk and accountability (Sheppard 1990; Peay 2003; Skinner 2006; Kinney 2009; Glover-Thomas 2011; O'Hare et al. 2013; Fistein et al. 2016; Stone 2017). As such this is less about crisis and more about the level of risk tolerance services are willing to accept. This thesis will deconstruct notions of risk and time, and socially constructed realities of crises in mental health care, extending an emphasis on early intervention (DoH 2014; Rooke 2020) to include the creation of a reality of practice that enables AMHPs to explore alternatives to admission in situations that are deemed by those referring to be a crisis.

Before proceeding any further, I will acknowledge that the referral for an MHA assessment and the MHA assessment itself are both nebulous concepts. The process of an AMHP beginning to co-ordinate an MHA assessment is triggered by the AMHP having "reason to think that an application for admission to hospital… may need to be made" (MHA 1983, s 13(1)). How the AMHP forms this opinion is not defined any further. While a person can be detained on the basis of two medical recommendations and an application for their detention, aside from the requirement that each professional sees the person there is no broader definition of the assessment save for statutory guidance that stipulates where possible the person being assessed should be seen jointly by an AMHP and at least one of the doctors prior to *being detained* (DoH 2015, chapter 14.45). There is no reference to those who are not detained within this guidance. However ill defined, these concepts are given meaning in practice to facilitate the enactment of this legislation. Broadly speaking there is a shared understanding of these concepts, subject to local practice variations to the extent that both the referral and the assessment are part of the reality of mental health practice in a socially constructed sense.

As a practising AMHP my interest is grounded in my practice experience and a growing appreciation of the complexities and contradictions within the role, as well as the wide margin of subjectivity apparent in how it is undertaken. Deciding whether to proceed with an assessment or not is fraught with competing demands and values, yet there is a stark

lack of literature focussing on this point in the decision-making process. My aim was to go some way toward rectifying this.

1.1.1 Aims and objectives

This study is an appreciative inquiry into AMHP decision-making at the point of referral for an MHA assessment, the aims of which were as follows:

1. To illuminate AMHP decision-making at the point of referral for an MHA assessment.
2. To generate knowledge and understanding of AMHP decision-making at the point of referral for an MHA assessment.
3. To offer AMHPs an opportunity to make use of this new knowledge and understanding in a way that is meaningful for their practice.

The study sought to achieve these aims by:

1. Focusing on AMHPs in one local authority.
2. Co-ordinating group discussions with AMHPs to understand their experience of decision-making at the point of referral for an MHA assessment.
3. Collaborating with AMHPs to identify how they might use this new knowledge to enhance future practice within the organisation.

In this chapter I will contextualise the experience of interest within legislation and practice. I will then seek to build on my practice foundations, offering an explanation about my position as a practitioner researcher and the integral use of 'I' throughout this thesis.

1.1.2 The AMHP

The AMHP role was introduced under the Mental Health Act 2007 (MHA 2007), an act amending the MHA 1983. All local authorities in England and Wales are placed under a duty to approve AMHPs. The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 paragraph 3(3) stipulate that such professionals will have carried out General Social Care Council (now replaced by Social Work England (SWE)) approved training and are identified under schedule 1 regulation 2 as social workers, mental health or learning disability nurses, occupational therapists or psychologists. The AMHP role existed before 2007 in a different guise under the MHA 1983 (as enacted), being entitled the 'Approved Social Worker' and was the preserve of social workers only, reflecting the social basis of the role. The expansion of professional groups permitted to take up the role since 2007 has sparked research into whether different professional groups approach the role differently. Stone (2017) identified that any differences were marginal, but that perhaps counter-intuitively, social workers had a greater focus on the importance of psychiatric medication; Vicary (2017) identified that the role itself defines

the professional rather than the other way around. The AMHP will be viewed in this thesis as comparable to the ASW because the role itself did not change with the MHA 2007 amendments, only the name and professional group entitled to take it up.

1.1.3 The legal context of the decision

The duties of the AMHP are dotted through the MHA 1983, but s 13 provides the key legal requirements of the role. It is the first of these duties that has inspired this thesis, and my interest is borne out of my role as a social worker and AMHP. I have been surprised by the lack of guidance or research into this part of the AMHP's statutory responsibilities, not least because on a personal level I find it the most complicated aspect of the role. I am referring to the following:

> "If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf" (MHA 1983 [as amended 2007], s 13(1)).

This is a re-wording of the original MHA 1983, which mentioned nothing of considering the patient's case and moved directly onto what has now been incorporated into s 13(1A):

> "It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him" (MHA 1983 [as enacted], s 13(1)).

1.1.4 The paucity of guidance

While the updated wording appears to highlight decision-making at the referral stage more so than the original wording due to the use of the word 'consider', it is not clear whether this rewording has made any appreciable difference to practice. There is no guidance offered to assist the AMHP to interpret what is meant by 'consider the patient's case'.

When the MHA 1983 was being revised in the early 2000s the government initially included a process whereby requests would be made to the responsible National Health Service (NHS) body, who would consider the evidence and determine whether the conditions for detention "appear to be met" (Joint Committee 2005, p.109), following which an examination (an MHA assessment) would be arranged if sufficient evidence was obtained. The government gave a commitment to provide guidance in the Code of Practice for

England about how such decisions would be made in response to concerns about vexatious requests (Joint Committee 2005). However, this draft of the Act was abolished in favour of an amendment Act which did not include this process, instead incorporating the words 'consider the patient's case' into the duties of the AMHP and without any accompanying guidance in the Code of Practice for England that was published in 2008. These words are present in a similar format under s 13(4) MHA 1983 in which the AMHP is required to "take the patient's case into consideration" at the request of a nearest relative (a relative specifically defined in the MHA 1983 according to a hierarchy). Section 21 of the Explanatory Notes to the MHA 2007 provides some detail about the amended wording to s 13(1) MHA 1983, illuminating an intention to maintain the link between the local authority and the AMHP, and together with s 13(1B) and (1C) to clarify which local authority is responsible for arranging the AMHP to consider the patient's case. As such it appears there was no intention to highlight decision-making at the referral stage in this redrafting, rather it was about aligning the AMHP with the local authority given the addition of other professional groups would mean some may not be employed by the local authority. The wording of s 13(4) MHA 1983 gives some indication of where the amended s 13(1) MHA 1983 wording emerged from.

Neither the MHA 2007 nor any subsequent government guidance goes so far as to say how the duty to consider the patient's case should be interpreted, and from a practice perspective AMHPs often do not interpret the request as an automatic trigger for an assessment to be arranged. Despite decision-making at this point in the process being acknowledged by professionals in the field, my experience is that professionals requesting an MHA assessment often do not value this aspect of the role and prefer to see the AMHP as the person who arranges an MHA assessment. This is a key notion in relation to the previous incarnations of the role.

The current Mental Health Act Code of Practice for England published in 2015 (there is a separate Code of Practice for Wales) contains a set of guiding principles offering some support to AMHPs with decision-making at the referral stage, but these are general principles and so lack specificity. The most widely invoked in practice is the principle of least restriction, which is defined as follows:

> "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" (DoH 2015, chapter 1.1).

Such guidance offers a useful starting point for any decision under the MHA 1983, including the AMHP decision to consider the patient's case under s 13(1) MHA 1983, though recognition of decision-making at this point is not explicit in the guidance. Additionally the Code of Practice goes further to highlight

> "Before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept" (DoH 2015, chapter 4.7).

However there is no recognition this decision could be made at the point of referral for an MHA assessment. In practice what is possible, safe and lawful, and what promotes independence and recovery is interpretive and so will differ from one situation to the next, and from one AMHP to the next. It is this variability and complexity that creates the experience of central concern for this thesis: How do AMHPs approach this decision? What influences the decision? How do AMHPs conceptualise this decision? How do AMHPs feel about this decision? These are the questions that interest me in my practice. They are the questions that have not been addressed in government guidance and there has been no research to date into this experience.

1.2 My perspective on the experience

This thesis is concerned with decision-making by AMHPs at the point of referral for an MHA assessment. As a practitioner researcher I am mindful that I have a reason for my interest in this area of study, and my motivation may not be shared by all AMHPs let alone wider professionals within the field of mental health. My fundamental belief is that an MHA assessment, particularly one carried out in someone's own home, can be highly intrusive and distressing, too frequently resulting in detention, and should only be conducted when all other avenues have been explored. When mental health professionals arrive at someone's home to carry out an MHA assessment it is often unannounced and unwelcomed. Usually there will be professionals present unknown to the person being assessed, and the required explanations about the process of the assessment and possible outcomes (detention in hospital) highlight what is at stake for the person assessed. While efforts can be made to manage this sensitively the prospect and even likelihood of detention is ever present by the assessment's very nature.

Research highlights detention itself is experienced as coercive (O'Donoghue et al. 2017), while Grace (2015) studied service user's experiences of detention and found "the process

of being assessed and detained actually increased symptoms of psychological distress" (p.52). Janner echoed this, reflecting on her subjective experience of an assessment in the context of depression:

> "I felt much more depressed about being assessed for compulsory admission to a psychiatric hospital than I did about the 'real' cause of my illness" (2005, p.16).

While the process of the assessment may be unpleasant, this may also affect the outcome, with the assessment itself possibly triggering an emotional crisis that makes detention in hospital more likely than if no assessment had taken place at all (Matthews 2015). Factors contributing to a poor assessment experience include the lack of familiarity with the staff assessing (Grace 2015), the communication skills of the assessors (Grace 2015), and the procedural nature of the assessment (Grace 2015). Murphy et al. (2017) similarly highlighted

> "the detrimental impact that the involuntary admission process had on [the service user's] psychological well-being" (p.1131).

Their study was conducted in Ireland under a different legal framework and with a different process of assessment and admission to hospital, but they highlighted "the need for significant improvement in the critical preadmission phase" (Murphy et al. 2017, p.1132). While their results relate to a different process of admission, the focus on the importance of what they term the *preadmission phase* is relevant: the key message being that the process of assessment and admission can be traumatic, and so this part of the process requires due consideration. However, Gregory and Thompson (2013) offered an account from Thompson's perspective as a service user being assessed under the MHA in her home. Her account highlighted she was neither aware she was being assessed nor was she particularly distressed by the event (Gregory and Thompson 2013). The result of her assessment was not admission or detention, which may have affected her overall experience, but it is worthy of note that not all MHA assessments have a negative impact upon the service user.

Since beginning this study an innovative piece of collaborative research has been published into the experience of those assessed under the MHA 1983, particularly in relation to the MHA assessment interview itself (Blakley et al. 2022). In this study those subject to these assessments were co-researchers, co-designing an interview protocol based on their own experiences. Ten participants with experience of MHA assessments were then recruited for interview. Key findings included that participants valued relational practice, and felt their

voice was absent from MHA decisions made about them. The overall experience was oppressive and the article calls for a more person-centred approach (Blakley et al. 2022). These findings provide compelling validation of my own experience and support the importance of this study into AMHP decisions at the point of referral for an MHA assessment.

My perspective is informed by my experience of MHA assessments since I qualified as an ASW in 2007. The assessment itself may be viewed as an example of coercion, yet the referrals for such assessments do not always appear to reflect this. There are some who view the assessment as helpful, a perspective I have some sympathy with in limited circumstances, but my overall experience is a negative one and I view the MHA assessment as something to be carried out as a last resort. Some have advocated, like Abbott (2018), that the assessment itself may offer a vehicle to access services, while others have seen detention in the face of poor community resources as a kind of "'getting-the-job-done' pragmatism" (Quirk et al. 2003, p.127). Of course, there will be some debate over what is considered the last resort, particularly when considering aspects of coercion in mental health practice. For example, should someone for whom an MHA assessment is being considered be made aware of this in the negotiations around their treatment? The Mental Health Act Code of Practice states:

> "The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)" (DoH 2015, chapter 14.17).

This guidance is sometimes interpreted in practice as preventing the discussion of an MHA assessment with a person during negotiations about admission or treatment, despite the withholding of key information contradicting the principles of empowerment and involvement, and respect and dignity (DoH 2015). Szmukler (2018) advanced an argument that distinguishes between a threat and an offer, central to which is a moral baseline. He suggested that if a person will not be worse off if they accept the offer then this would be an offer, whereas if they would be worse off this would constitute a threat (Szmukler 2018). If detention is the moral baseline then accepting treatment or voluntary admission represents an offer (Szmukler 2018). The interpretation then must follow that the possibility of an MHA assessment cannot be invoked erroneously, otherwise the moral baseline is not detention and so invoking that possibility becomes a threat. However, if transparency is maintained:

> “many patients, if it comes down to a bare choice, would see succumbing to a threat as preferable to a formal involuntary admission” (Szmukler 2018, p.165).

Szmukler (2018) went on to advocate for a formalised procedure when such coercion is used to promote treatment adherence in the community or voluntary admission, therefore maintaining transparency about when such measures are utilised to facilitate adherence. While coercion is a difficult concept to advocate for, transparency is a core social work value (SWE 2019).

There is no reliable data showing how many assessment requests result in a traditional MHA assessment, partly because neither the request nor the assessment are defined entities, and partly because there is no agreed national data set. There is also no national data about how many assessments result in detention, as only the detention statistics are recorded (NHS Digital 2021). Walton (2000) analysed data from one local authority over the five years between 1993 and 1998, identifying alternatives to detention were found by ASWs in 18% of assessments where two doctors made medical recommendations for detention. This statistic does not include the number of assessments not resulting in detention where doctors did not make medical recommendations, which would presumably be higher. More recently Abbott (2018) identified detention was the result of every assessment discussed by participants in his study. Wickersham et al. (2020) identified 70% of assessments resulted in detention in the quantitative aspect of their study in inner-London. Davidson et al. (2021) carried out an audit of MHA assessments in Northern Ireland, and while in a different legal context, their audit highlighted 82% of people were detained following assessment. These studies support a contention that MHA assessments most frequently lead to detention.

In my experience many assessment requests will not result in an MHA assessment, with some less restrictive alternative being identified by the AMHP in consultation with others; some assessments that are convened will not result in the detention of the person; of those people who are assessed and detained some may have been detained by the professionals in attendance in part because those professionals were approaching the situation with detention in mind (Peay 2003; Buckland 2016); further, the assessment itself may trigger an emotional crisis that makes detention in hospital more likely than if no assessment had taken place at all (Matthews 2015); and assessments are experienced negatively by service users subject to them (Grace 2015; Murphy et al. 2017; Blakley et al. 2022). If these points are accepted, then the rationale to ensure an assessment is convened

as a last resort is compelling and highlights the importance of decision-making at the point of referral for an MHA assessment.

1.3 My status as practitioner researcher and the use of "I"

Throughout my ASW/AMHP career I have found the decision at the point of referral for an MHA assessment very challenging, yet when I have sought to learn more about it I have found no literature on the matter. Lunt et al. (2012) described this as a "'practice puzzle'" (p.187) and this puzzle seemed the obvious choice for my research proposal. Epstein (2002) encapsulated in the following my desire to "answer questions that emerge from practice in ways that inform practice" (p.17). So, without knowing it at the time I had already identified that I wanted to adopt a practice-based research approach.

Herein lay the necessity for the use of the first person in this thesis, for the importance of the experience of interest has emerged from my practice. I remain in practice as I complete this study and so continually experience receiving a referral for an MHA assessment. My subjective position in relation to this experience is my motivation to study it; writing in the first person allows me to embrace this subjectivity and maintain transparency throughout the thesis.

The legislation has created the experience, but the exploration of that experience has been largely ignored within the literature. Discussing the experience with colleagues over time has shown me that there is a shared understanding between AMHPs, and so from a social constructionist perspective this experience is a constructed reality.

Marsh and Fisher (2005) identified that

> "research that begins and ends in practice that is genuinely 'practice-based evidence' is lacking in social care" (p.15).

This appears somewhat surprising given my inclination toward this approach, but on further analysis the reasons to me at least become clearer. As a social worker I am familiar with the term evidence-based practice; indeed, in relation to the topic of this thesis schedule two of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 stipulate that AMHPs should

> "base AMHP practice on a critical evaluation of a range of research relevant to evidence-based practice" (2(e)(ii)).

Dirkx (2006) conceptualised traditional evidence-based research as a process whereby

> "practitioners receive the wisdom of the researchers and apply it technically to particular problems of practice" (p.280).

Epstien (2002) located this approach within a positivist paradigm with a desire to prove interventions work, whereas he views practice-based research as inductive and "derived from practice wisdom" (p.18). This recognition solidified my resolve toward practice research, for in my journey to a methodology and an understanding of philosophical concepts I was particularly drawn to notions of expertise and practice wisdom. Polanyi's (1966) notion that "we can know more than we can tell" (p.4) was compelling, with the example that we may know a person's face but not be able to describe how we know it; we recognise the whole but without being able to explain the constituent parts. Dreyfus and Dreyfus (1984) cited Plato on this issue in a dialogue with Socrates who sought rules of prediction: "Experts once had known the rules they use, Plato said, but they had forgotten them" (p.219). In fact, they went on to propose that an expert "intuitively sees what to do without applying rules" (Dreyfus and Dreyfus 1984, p.226). This fit with my sense that rule bound or procedural approaches to social work befit the novice, but expert practitioners intuitively respond to nuances in people's circumstances to inform their practice. Of mental health professional decision-making Glover-Thomas (2011) found something similar, where "decision-makers cannot define risk in the abstract, but they know it when they see it" (p.603). This all reinforced my sense that I did not want to subject participants to the wisdom of my interpretive efforts, but rather bring their expertise into this interpretation to co-produce understanding.

An approach which values experience and seeks to build theory from practice (Uggerhoj 2011) seemed befitting my status as a practitioner researcher. As an experienced practitioner but novice researcher, the opportunity to draw on my strengths as a practitioner and embrace my practice in the pursuit of new knowledge felt liberating, a duality Pain (2011) considered positive.

1.4 My philosophical position

What will be clear by now is that I do not consider there to be a definitive answer to the question of whether someone requires an MHA assessment or not; there is no objective truth to be uncovered. My reality is interpretive; the AMHP will build a sense of reality from a situation in order to reach a decision. Researching this experience has necessitated a qualitative approach, following a process of discovering the quality of the experience (Reed 2007).

1.4.1 Social constructionism

One philosophical position that resonated with me was social constructionism, where

> "knowledge is a subjective reality—a social artifact resulting from communication among groups of people" (Whitney and Trosten-Bloom 2010, p.51).

In relation to AMHP decision-making, this perspective would assume there is not an objective truth in the positivist sense where the task of the AMHP is to successfully identify which people fall into which category; rather the defining characteristics and circumstances that constitute the need for an MHA assessment will be subjective but shared among AMHPs through language. Whitney and Trosten-Bloom (2010) went on to reinforce this shared dimension:

> "Knowledge—that which is considered good, true, and meaningful—is a broad social agreement created among people through communication" (p.53).

Collectively AMHPs may create knowledge about who requires an MHA assessment and who does not through communicating with each other and establishing the parameters of this constructed reality. From my practice experience I believe there is much merit in adopting this perspective on the nature of reality. Despite the independence of decision-making within the role, my experience has shown me that AMHPs will talk through their practice dilemmas with their colleagues and in so doing may begin to construct a reality through language with their colleagues. Berger and Luckman (1966) highlighted how in social constructionism it is this process of verbalising our ideas that clarifies our thoughts and makes them real. This may be viewed as a form of reflection in action, where we may "reshape what we are doing while we are doing it" (Schön 1987, p.26).

The construction of reality in social constructionist terms promotes language as a means of creating reality, and it is this central tenet after Schön (1987) that allows the reflective practitioner to make sense of complex social situations.

This study sought to understand an experience; but as a practitioner I didn't want to stop there. I wanted this study to have a practical application. As a practitioner I am interested in what can be learnt from practice. The link between social constructionism and reflective practice highlights how such an endeavour is consistent with a social constructionist understanding: meaning can be recreated within reflective social interactions. Berger and Luckman (1966) described how in social constructionism institutionalisation occurs where habituated actions are developed and deviance is viewed as a departure from reality.

Challenging this reality requires effort, but a critically reflective space affords just such an opportunity to achieve this. From a social constructionist perspective, the reality of AMHP decision-making at the point of referral for an MHA assessment is created, maintained and reshaped through language. Social constructionism embraces a world of multiple realities rather than clinging to the concept of one objective truth.

There are other philosophical positions that have also influenced me, particularly when considering the practical application of knowledge gained from this study, namely critical realism and pragmatism.

1.4.2 Critical realism

Critical realism adopts a layered view of the world, with the layer of the real being hidden, the layer of the actual being obscured but known about, and the layer of the empirical being that which can be seen and studied (Walsh and Evans 2014). By studying what we can see and accepting what is obscured we can learn about reality even though we cannot see it: we know it is real because we can see its effects (Walsh and Evans 2014). In relation to AMHP decision-making at the point of referral for an MHA assessment, a critical realist perspective would view there being a reality impacting practice which can be studied by focussing on practice: decisions can be traced back to their real roots. Critical realism accepts multiple realities but does not consider them to be equal, with practitioners seeking an interpretation they feel confident they can base their practice on (Porter 2007). Houston (2010) helpfully summarised critical realism as the acceptance of an intransitive world (the real world) that individuals construct a transitive understanding of. Transitive understanding becomes more refined and therefore closer to the intransitive reality through sophisticated theory development (Houston 2010). So, some constructions of reality are closer to the intransitive or true reality.

Critical realism also highlights a moral dimension to reality with an emphasis upon emancipation (Deforge and Shaw 2012). Crucially, critical realism seeks a synthesis of stakeholder opinions on a topic before reaching a reality that is acceptable to all (Pawson and Tilley 1997). This then would add a dimension absent from this study, namely a range of perspectives on AMHP decision-making. The study would then become what a range of stakeholders feel about how AMHPs should make decisions at the point of referral for an MHA assessment. This was not the aim of this study and so it cannot be viewed as consistent with critical realism.

1.4.2.1 The focus on AMHPs

This study is not the definitive study of AMHP decision-making at the point of referral for an MHA assessment; rigour was achieved through the transparency of method; the study is replicable because of this, but the knowledge generated from this study is about the unique experiences of the AMHPs participating in the study. The results are subjective to the experience of the participants, and ultimately insight into the experience is partial. Yet as the first study into this AMHP decision the knowledge generated is valuable as a way of beginning to understand the experience. Hughes (2011) carried out a unitary appreciative inquiry into the experiences of five student social workers approaching qualification, recognising that we can

> “learn from these unique experiences to enhance our understanding of a particular context” (p.697).

This study sought to learn more about the context of AMHP decision-making at the point of referral for an MHA assessment by drawing on the unique experiences of the participants, beginning a dialogue on the experience.

AMHPs retain sole responsibility for their decision-making at the point of referral for an MHA assessment, yet may speak to a range of people to help inform this decision. They may gather information from a range of sources and synthesise this with the stakeholder opinions they have received. They may involve the service user directly in their decision-making, or the service user may never know they are being considered for an MHA assessment. The AMHP is at the centre of a complex web of information and is the only person in the process holding all the information; the experience of the decision is uniquely an AMHP experience. Trying to gain a consensus between all stakeholders, while unrealistic, was also not my desire in this study. This study was about how AMHPs view their current practice, and how they would like their practice to be enhanced in the future. If this does not correlate with the perspective of other stakeholders in the decision, that does not diminish the importance of illuminating decision-making at the point of referral for an MHA assessment. This study is about AMHPs and their practice. The outcomes from this study do not define who needs an assessment; no consensus is sought about this. As such critical realism does not offer a coherent philosophical position for this study.

1.4.3 Pragmatism

Pragmatism does not seek to define reality, rather the focus is on what use can be made of knowledge: inquiry is judged by its application to practice (Reed 2007). Starting from the assumption that we are our experiences (Deforge and Shaw 2012), pragmatism focusses more on what we can learn from those experiences rather than trying to uncover an underlying truth (Deforge and Shaw 2012). Koopman (2006) clarified that from a pluralist position of multiple realities, and a humanist position that humans can contribute to forming these realities, philosophical hopefulness, or meliorism, combines in pragmatism to conclude that we can create better worlds for ourselves democratically. This merging of pragmatism with hopefulness is compelling in its optimism about the future; however, pragmatism is typically associated with problem solving (Sun and Kang 2015), therefore starting from a negative position. Koopman's (2006) meliorism values practice currently while also understanding there will always be scope to improve practice for the future. This speaks directly to the essence of what I hope this study has achieved: the dual benefits of understanding alongside enhanced practice outcomes for the future.

Morgan (2014) drew attention to how pragmatism affords social communities the freedom to define the issues that matter and address them in a way that is meaningful to them. In this sense pragmatism has relevance to this study of AMHP decision-making at the point of referral for an MHA assessment: understanding what happens now is important because of what use can be made of this new knowledge. This fits well with reflective learning, and Sun and Kang (2015) viewed work-based learning as consistent with pragmatism, but they cautioned against a technical approach at the expense of a more holistic model of learning encompassing humanism. Pragmatism in this sense is interpreted as learning from experience in a narrow and technical sense, reducing the applicability of outcomes due to the specificity of focus. However, this interpretation fails to acknowledge Koopman's (2006) meliorism and humanism, whereby the development goals sought are defined by the community and targeted at creating a better world; in this sense holistic and lifelong learning goals may be incorporated into a pragmatic approach to human development if this meets the desire of the community.

The central difference between critical realism and pragmatism is the concept of truth. Both approaches seek a practical application of new knowledge, and both approaches view

inquiry as a process of growth. This study into AMHP decision-making at the point of referral for an MHA assessment focussed on a very specific area of practice; the study did not seek to define who requires an assessment under the MHA 1983; this study sought to understand the AMHP narrative on the topic, allowing AMHPs to define the issues that matter to them and pursue practice development in a way that was meaningful to them, as conceptualised by pragmatism (Morgan 2014).

1.4.4 Summary of philosophical positions

Social constructionism, critical realism, and pragmatism are founded on the construction of knowledge through language. Bringing people together to share experiences accepts the role of language in creating meaning. Social constructionism supports the reshaping of reality in a social context. Pragmatism places the emphasis on the practice benefit, while critical realism emphasises seeking the intransitive reality before searching for ways in which this knowledge can be usefully applied in practice. This study aligned closely with both social constructionism and pragmatism. Critical realism lacked credibility in this study because the layer of the real was not accepted; the study did not seek to define who needs an MHA assessment, rather it asked AMHPs about the best of their experiences and worked collaboratively with them to reach their desired future. This desired future may represent a reality, but it was not an objective reality because other people may have different views than those involved in the study. Social constructionism may offer the overarching philosophical position in relation to meaning-making in this study, but pragmatism in its most hopeful sense offered the tangible practice-based goals that I sought as a practitioner.

Chapter 2 History of the AMHP role

2.1 Decision-making in the previous incarnations of the AMHP role

I have explained the AMHP/ASW role as defined by the MHA 1983, however its origins date much further back. This chapter will turn to the earlier incarnations of the role to offer an insight into the purpose of their creation and how and why this has changed. I will draw some parallels between decision-making in these earlier roles and the role today to offer a thread of consistency over time, while at the same time highlighting the fundamental differences.

2.1.1 Overseer

The AMHP role may be traced back to 1743 and that of the 'Overseer of the Poor' under the English Poor Law system, where a constable, church warden or overseer could "apprehend a dangerous lunatic" (Bean 1980, p.61). This was however based on a warrant from two justices, and indeed sounds highly custodial and plainly with a public protection emphasis. Such a power is perhaps more akin to s 136 of the MHA 1983, where a police officer is afforded the power to take a person who appears to them to be suffering from a mental disorder to a place of safety if they are in immediate need of care or control, albeit they can do so without a warrant from court.

Hargreaves pointed to the County Asylums Act 1808 as the origin of the role, where the Overseer was tasked to identify those considered to be lunatics and to bring them before a Judge (Hargreaves 2000). This absence of judicial involvement prior to identification brings the Overseer post 1808 closer to today's AMHP. However, the Overseer was only involved in the absence of a relative and so was not considered to have any expertise. Perhaps as a legacy from these times the MHA 1983 contains a 'nearest relative' role which is specified under a hierarchy, and the nearest relative has the same power to make an application for detention in hospital as the AMHP. This is a somewhat contradictory aspect to their other functions which are deemed to be safeguards against unjustified detention, such as the nearest relative's power to discharge a patient from detention or prevent an AMHP from making an application for detention for treatment under s 3 MHA 1983, which lasts up to six months.

The courts then were central to the detention process, but the Overseer had the responsibility of identifying those who may require detention for the Courts to consider. There may be a parallel here to the decision-making today by AMHPs, who as discussed have a statutory responsibility to consider the patients case where they have a reason to think that a person may need to be detained in hospital. One principal difference is that there is no longer a role for the judicial system at the detention stage, and so now the AMHP makes the application for detention rather than a Judge, bringing into sharp focus the independent decision-making inherent in the role now. Additionally, the ethos under the County Asylums Act 1808 was to remove people deemed a nuisance or danger to society to asylums outside of populated areas (Jones 1979) and therefore the Overseers were part of a system of social cleansing and public protection; Lord Newton described the focus as primarily custodial rather than medical (HL Deb 4 July 1962), a perspective many would find objectionable today. The AMHP role today is viewed more as a safeguard against a purely medicalised system, with detentions being viewed as more benevolent than custodial, though as will be highlighted in my literature review risk remains a prominent factor in decisions to detain under the MHA 1983.

2.1.2 Relieving Officer

The Lunacy Act of 1890 termed the role the ‘Relieving Officer’, and they fulfilled a similar function to the Overseer allowing cross-comparison. Jones (1993) however highlighted police officers also held the same responsibilities, echoing my earlier parallel to the police powers today under s 136 MHA 1983, further adding to the public protection and social cleansing ethos, and supporting that the Relieving Officer was not expected to have any expertise. Medical evidence was sought by the court once the Relieving Officer had identified the ‘lunatic’, but Hargreaves (2000) also suggested often a doctor identified the ‘lunatic’ first and would call the Overseer to bring them before a Judge. In this case the element of decision-making by the Overseer is less clear and perhaps could be viewed as ancillary to their administrative and organisational functions. Nevertheless, they were acting as an individual (Hargreaves 2000) as AMHPs do today, and so were required to be satisfied themselves that their actions were appropriate. As mentioned above however, the Overseer and Relieving Officer were both functioning as a surrogate relative, and so their autonomy was not viewed as synonymous with expertise. Bean provided an example from 1928, in which a Relieving Officer contradicted medical opinion. They were criticised for doing so by the coroner, who did however recognise they were acting in accordance with

their legal rights (Bean 1980). The dominance of medical opinion is clear within such criticism, as is the perspective that the primary function of the Relieving Officer was administrative.

It is worth taking a moment to reflect upon the current administrative functions of the AMHP role, which remain significant. The Mental Health Act Code of Practice identifies the AMHP as usually responsible for the arrangement and co-ordination of the assessment (DoH 2015, chapter 14.41), and the AMHP continues to be responsible for arranging the transportation of the detained person to hospital under s 6(1) MHA 1983, just as the Overseer was responsible for arranging transport to the asylum under the County Asylum’s Act of 1808. Such administrative functions have therefore always been an important part of the role, as clearly any mental health law concerned with detaining people in hospital must identify someone to carry out such responsibilities if they are to happen at all. Few AMHPs see themselves primarily as administrators, focussing more on bringing a social perspective to bear upon decision-making as reflected in the MHA Code of Practice (DoH 2015, chapter 14.52). However, it seems clear the history of the AMHP role is embedded in these administrative functions. Given the significance of administration still today, it is perhaps understandable that some people not performing the role may view it predominantly in this light.

2.1.3 Duly Authorised Officer and Mental Welfare Officer

Prior to the Mental Treatment Act of 1930 there was no option of voluntary admission to a mental health hospital, perhaps by virtue of there being no therapeutic benefit to such admissions (HL Deb 4 July 1962). As Lord Newton further described detention in asylums was almost entirely a custodial matter, with only a marginal medical element to it (HL Deb 4 July 1962).

With the introduction of the National Health Service in 1948 the Relieving Officer became the ‘Duly Authorised Officer’ (DAO). The Percy Commission was set up to review the Mental Treatment Act 1930 in 1954, and Lord Percy’s reflections on the DAO role highlighted the responsibility merely for transportation yet with independent public protection duties was somewhat disparate (cited in Hargreaves 2000). This point was made in part to draw attention to the independent functions of the DAO, which were largely unappreciated. It comes across as a criticism of their independence, yet this independence was retained in the Mental Health Act 1959. The Percy Commission’s expectation of the newly named

'Mental Welfare Officer' was that they would be given sufficient training to ensure they did not disagree with medical opinion (Hargreaves 2000), yet it was paradoxically accepted that in giving them a statutory responsibility, they could not be duty bound to comply with someone else's instructions (Bean 1980).

What is clear from the Mental Health Act 1959 is that it moved away from the earlier judicial system under the lunacy laws to a medicalised system where, as Lord Newton termed it, informal admission was the normal procedure and compulsion was deemed a medical not a judicial matter (HL Deb 4 July 1962). The retention of the independent non-medical Mental Welfare Officer may be viewed as recognition of the need for some form of protection (Bean 1980) but the expectation that sufficient training should result in conformity with medical opinion undermines this position and suggests the Mental Welfare Officer was a tokenistic offering in this regard. This perspective was echoed by Gostin (1975), who pointed to the relative's ability to make an application for detention and suggested the fact that parliament gave the Mental Welfare Officer's opinion no more weight than a relative would indicate the professionalism of the role was not held in high esteem. Additionally, the 1959 Act did not stipulate any professional requirements for the Mental Welfare Officer, nor any expectations surrounding expertise.

The autonomy bestowed upon the Overseer, Relieving Officer, Duly Authorised Officer and Mental Welfare Officer was apparently then not valued, yet it remained present within the statute from 1808. Viewed perhaps as a necessary evil but highlighting what seems in retrospect the inevitability that where such autonomy exists the role ought to be carried out by someone with adequate expertise.

2.2 The Mental Health Act 1983

When the MHA 1983 was in its inception, Gostin (1975) argued for independent decision-making for social workers with a focus on social factors and less restrictive alternatives to admission. The British Association of Social Workers (BASW) (1977) echoed this position, viewing who they termed ASWs as experts in family and social functioning, and that such expertise should complement the medical opinions. They further recommended specialist training to equip ASWs to reach independent decisions. Pritchard and Butler (1976) had viewed such specialist training as essential to bring the social worker's opinions parity with medical opinions, something which Bean's (1980) study considered "absurd" (p.166) under the 1959 Act. In the development of the ASW role then there was a clear move toward

creating an appreciable safeguard to what was viewed as an overly medicalised system by strengthening the autonomy of the role and raising the standard of practice through specialist training. The MHA 1983 affirmed the autonomy of the role, requiring the ASW to:

> "interview the patient in a suitable manner and satisfy himself that detention in hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need" (s 13(2)).

The adoption of the title Approved Social Worker carried the requirement that ASW's would hold a professional social work qualification, and the Act stipulated local authorities should only approve people to act as ASW's if they had "appropriate competence in dealing with persons who are suffering from mental disorder" (MHA 1983, s 114(2)), together going some way toward addressing the training requirement. This was enhanced in a Local Authority Circular to require "specialist knowledge and skills" (Department of Health and Social Security (DHSS) 1986, paragraph 14), with clarification that the ASW role was to "prevent the necessity for compulsory admission to hospital" (DHSS 1986, paragraph 14), perhaps the strongest statement about the wider role of the ASW before or since.

The role of the nearest relative to make an application for detention rather than an ASW was retained under the 1983 Act however, suggesting that despite the apparent importance of autonomy and professionalism there remained some ambivalence about this within government. In fact, s 11(1) MHA 1983 lists the nearest relative first as the applicant for admission, a legacy perhaps from the Lunacy laws. The Mental Health Act Code of Practice states the "AMHP is usually a more appropriate applicant" (DoH 2015, chapter 14.30) though it seems this preference is yet to reach primary legislation. Prior (1998) highlighted this ambivalence as a fundamental contradiction within the legislation, and this remains outstanding.

Under the MHA 1983 then, where two medical recommendations were made for a person to be detained in hospital the ASW was tasked to form an independent opinion about the necessity of this. The MHA 1983 provided the legal framework, and the ASW was tasked to make a judgement about the appropriateness of detention in a psychiatric hospital. This decision can be viewed as quasi-judicial as it relates to the interpretation of how the MHA 1983 might apply to an individual and their unique circumstances. Such a position is a clear departure from the medical dominance within the 1959 Act and suggests a partial return at least to a judicial system of mental health law. That social workers occupied this position offers further evidence of a move away from the medicalisation of mental disorder, and

indicates a partial acceptance that mental disorder may have started to become understood as a social problem as well as a medical one. Pilgrim (2014) located mental health work in the sphere of encouraging conformity to social norms, and Sheppard (1990) reflected on the role of ASW's as rule enforcers where symptoms of mental disorder may be considered deviance from social norms. Sheppard (1990) compared the ASW role to the interpretation of laws usually reserved for higher courts. Sheppard went on however to acknowledge a social context to such decisions, broadening any purely judicial interpretation of the role and returning to the primary intention of parliament to introduce a social perspective to the detention process (Sheppard 1990).

The issue of public protection is an interesting one in relation to mental health law in England and Wales. As already mentioned, this was a clear intention of the asylum system, and the Percy Commission chose to perpetuate the conflation of doing what may be in the person's best interests while also protecting others in what ultimately became the 1959 Act (Bean 1980). The MHA 1983 retained what may be considered the risk criteria of the 1959 Act, namely that persons with mental disorders could only be detained if necessary for the health or safety of the person or the protection of harm to other persons.

The Richardson Committee was set up in 1998 as an expert committee to review the MHA 1983, and in 1999 recommended a test for capacity be introduced into the Act with a higher threshold of risk and treatability for the detention of those with capacity (Peay 2000). The government quickly dismissed this idea on the basis that capacity was irrelevant, and that the principal concern was the degree of risk patients with mental disorder posed to themselves or others (DoH 1999). Zigmond and Holland (2000) drew attention to the underlying assumption of the government that those with mental disorders must be dangerous and therefore should be treated differently from those with physical health problems, and they highlighted the 'beyond reasonable doubt' test within criminal law affording those without mental disorders a higher level of protection from arbitrary detention than those with mental disorders. The MHA 1983 retained the risk criteria above, maintaining a public protection focus arguably uninterrupted for over 200 years. From a practice perspective conversation about risk takes place at an early stage in the process of considering an MHA assessment, while Stone (2019) identified a "strong emphasis upon the assessment and management of risk" (p.85).

Another potential influence on a legal framework for compulsory treatment is one of resources. Zigmond and Holland (2000) suggested there is no need to develop resources

acceptable to patients when detention is an option, and the Richardson Committee recognised this promoting what they termed reciprocity; a parallel duty on health and social care to provide services of an appropriate standard (cited in DoH 1999). Butler and Pritchard (1983) championed this perspective, yet twenty years later inadequate resources continued to contribute to detention decisions (Quirk et al. 2003) and little appears to have changed since then given renewed calls for parity of esteem with physical health (Mental Health Taskforce 2016).

2.3 The 2007 amendments

In 2007 the amendment Act was passed and the ASW role was replaced by the AMHP, extending the professional groups of those entitled to take up the role to mental health or learning disability nurses, occupational therapists and psychologists. The independence of the role was retained alongside an expectation from the government that the primary function would be to bring a social perspective to the assessment process (DoH 2008a, chapter 4.51).

Both the MHA 1983 and the MHA 2007 amendments lack clarity about how the process of an MHA assessment is instigated. In reviewing the 1983 Act the DoH produced the *Draft Mental Health Bill* in 2004 including a responsibility upon the appropriate authority to respond to requests by considering whether the detention criteria appear to be met before then organising an examination (a Mental Health Act assessment) if required (DoH 2004). The report of the Joint Committee in 2005 clarified the appropriate body would be the NHS body, and the Code of Practice for England would include guidance on how these decisions would be made (Joint Committee 2005). However, this draft bill was dropped and instead the wording of s 13(1) was amended, the AMHP now required to 'consider the patient's case' where previously the duty (still present) was to make an application where he believes it ought to be made (s 13(1) under the MHA 1983; s 13(1A) under the 2007 amendments). The focus of this thesis is on this point in the process of an MHA assessment, which given the ambiguity in the wording creates unique challenges and leads to wide variability in the interpretation of what should occur.

2.4 The current context

In 2009 the UK government ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) 2006. Article 4 of this convention calls for governments to review all legislation and modify or abolish any laws, regulations, customs or practices

that discriminate against people with disabilities. Article 12 calls for equal recognition before the law, and article 25 requires all health professionals to provide care of the same quality to persons with disabilities as to others. In response to this commitment the Mental Health Taskforce (2016) set a transformation agenda in which they cite the ambition to eliminate inequality and offer parity of esteem with physical health by 2021, offering a significant contribution to the earlier calls for reciprocity from the Richardson Committee in 1999. Together with the government's current plan to reform the MHA 1983 to ensure mental health is prioritised by the NHS, and to provide greater rights to those experiencing mental health problems (Prime Minister's Office 2017), the legal and policy landscape are moving to address the challenges set by the UNCRPD 2006. The rate of detention under the MHA 1983 is rising (Care Quality Commission 2018), something acknowledged in the current review of the MHA, and cited in the final report of the independent review chaired by Sir Simon Wessely, which went on to promote greater patient choice and a reduction in coercion and risk aversion (DHSC 2018). Acknowledging risk as a primary issue in decisions to detain under the Act, and citing concerns about risk aversion amongst professionals, the current review has committed to consider how positive risk taking can be supported by a new Mental Health Act (DHSC 2018). Whether such a commitment will translate into legislation remains to be seen.

At the time of writing the Draft Mental Health Bill 2022 has been published, which includes raising the risk threshold for detention through the use of the term 'serious' harm, coupled with consideration of the nature, degree, and likelihood of that harm, and how soon that harm will occur (DHSC 2022, s3(2) and s3(3)). This draft bill makes no proposed changes to the topic at the heart of this thesis, the AMHP decision at the point of referral for an MHA assessment. The Joint Committee appointed by the House of Commons and House of Lords have reviewed the draft bill to consider how to better achieve the government's aims (Joint Committee 2023). Guidance in a new Code of Practice was encouraged about the notion of 'serious' harm, due to concern this may exclude some who would benefit from earlier intervention (Joint Committee 2023). This appears a cautionary stance that may reverse the intention to raise the risk threshold. Earlier calls from the MHA review (DHSC 2018), to incorporate the principles of the MHA into the legislation, have not materialised in the Draft Bill (DHSC 2022), and are discouraged by the Joint Committee (2023), a distinct move away from a rights-based legal system. Interestingly for this thesis, the Joint Committee noted calls for a fundamental review of the legislation rather than further amendments. The Joint Committee, while supporting the current amendments, have also advised the

government to continue the process of review toward fusing the MHA 1983 and the MCA 2005, placing greater emphasis on human rights, and incorporating new Code of Practice guidance about those with decision-making capacity who refuse admission and treatment (Joint Committee 2023). Equally both the DHSC (2018) review, and the Joint Committee (2023) highlight the need for investment in alternatives to admission, echoing the earlier commitment raised in the NHS Long Term Plan (NHS 2019). There are some longer-term ideals then that appear somewhat out of reach for the current legislative review, yet those ideals reflect some key considerations for AMHPs when considering a social perspective.

The United Nations have set the bar high for mental health law, policy and practice. Article 12 of the International Covenant on Economic, Social and Cultural Rights 1966 promotes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12 of CPRD 2006 promotes equal recognition before the law and article 14 promotes liberty and security of person. The United Nations Committee on the Rights of Persons with Disabilities 2014 offered a general comment to article 12 in which it advocated for the absolute protection of every human being's right to the exercise of legal capacity, and a parallel relationship was highlighted with article 14 in that no person should be subject to mental health detention and enforced treatment against their wishes. This was echoed by the United Nations Human Rights Council 2017 in which a call was made for an end to all forced psychiatric treatment and confinement. This seems practically unrealistic, and the current independent review has dismissed the desirability of such drastic change, however a movement toward reducing detentions is suggested (DHSC 2018).

The task of interpreting how our laws can align closer to these aspirations is one for legislators and policy makers but, AMHPs remain uniquely positioned to promote a human rights-based perspective given their position as decision-makers under current mental health law in England.

2.5 Conclusion

The role of the AMHP was introduced in 2007 but is an amended version of the ASW introduced in 1983. Prior to 1983 the role existed in various guises, building from its roots in social control and public protection in the 18th century, being predominantly administrative but with a concurrent element of autonomy that evolved into more specialist mental health practice in the years between the 1959 and 1983 Acts. What is

clear is that autonomy and professionalism within the role have only been truly valued since 1983. The 2007 amendments strengthened this position further and the introduction of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 formalised a framework for establishing the expertise of the role. After grappling with changing the law to introduce a new responsibility for NHS bodies to make decisions about whether people required a formal assessment under the Mental Health Act, the government abandoned these plans and left this responsibility with AMHPs. Despite an earlier commitment to provide guidance in the Code of Practice to support decision-making at this stage this has yet to materialise in either the 2008 or the current 2015 version for England, so AMHPs are left to interpret these responsibilities for themselves. Hargreaves (2007) suggested under the 1983 Act ASW's could be directed to undertake an assessment by the local authority. In fact, this wasn't explicit in the 1983 Act, and it is perhaps less so now with the inclusion of the words 'consider the patient's case' in the 2007 amendments.

Chapter 3 Literature review

A structured narrative literature review of Approved Mental Health Professional detention decisions: an infusion of morality.

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3.1 Abstract

Aim: In England and Wales, Approved Mental Health Professionals (AMHPs) may make applications to detain people in hospital under the Mental Health Act (MHA) 1983. In this chapter I will establish what the available academic literature has to say about AMHP detention decisions to provide a contextual basis for exploring AMHP decision-making at the point of referral for an MHA assessment.

Method: I have conducted a structured narrative literature review with the identification of twenty-nine included texts, that were thematically analysed interpretively.

Results: I have identified risk, accountability, and morality as dominant themes in this review. Risk is prominent, but on closer inspection risk is infused with morality. Morality is the merging of the personal and professional domains, the use of self to understand another. Accountability is situated between morality and risk, inextricably linked on both sides with authors identifying a fear of responsibility for adverse consequences. I also found sub-themes of emotions, intuition, uncertainty, coercion, and alternatives (to admission to hospital). My analysis of thirty years of literature regarding AMHP detention decisions suggests that they are not based solely on technical judgements; morality permeates the decision. The literature is justified in evincing risk in detention decisions, but the prominence of risk overshadows accountability and belies the influence of morality.

3.2 Introduction

The role of the Approved Social Worker (ASW) was introduced in the England and Wales Mental Health Act (MHA) 1983, the purpose being to bring the social perspective to bear upon detention decisions as advocated for most notably by Gostin (1975) and the British Association of Social Workers (1977). When the MHA 1983 was amended in 2007 the ASW was renamed the Approved Mental Health Professional (AMHP), a role extended beyond

social workers to include mental health or learning disability nurses, occupational therapists and psychologists. Its remit did not however change. In this thesis I am concerned with AMHP decision-making at the point of referral for an MHA assessment. At the point of a referral for an MHA assessment the AMHP has a duty to “consider the patient’s case” (s 13(1) MHA 1983) a decision which is completely independent. The AMHP will consult with others involved to inform the decision, but ultimately the decision is theirs alone. The AMHP functions as the logistical co-ordinator of the assessment process, but due to the independence of their role they are not working at the behest of any other person or organisation. As such when an AMHP is approached to ‘consider the patient’s case’ an MHA assessment is not automatically arranged. The AMHP must at this point decide whether an MHA assessment is warranted. Based on my initial scoping review decision-making by AMHPs at this stage of the MHA assessment process has attracted little attention, and any references in the literature are fleeting. What has been studied more widely is AMHP decision-making concerning detention under the MHA 1983, and as such this will form the basis of my literature review. References in the literature to decisions at the point of referral for an MHA assessment will also be incorporated. Where the detention decision is different from the decision to proceed with an assessment is that not including emergency or criminal justice provisions, detention decisions are made including three professionals: a doctor with previous acquaintance if possible; a doctor approved under s 12(2) MHA 1983 with specialist knowledge in treating mental disorder, two s 12(2) approved doctors if the former doctor with previous acquaintance cannot be achieved; and an AMHP. All three have a statutory responsibility in the assessment process: medical recommendations are founded on grounds set out in s 2(2) or s 3(2) MHA 1983 which include implicit risk criteria including health or safety of the person or the protection of harm to others, which from my analysis has translated into risk being identified as a theme in this review; while the application for detention made by an AMHP is founded upon broader terminology set out in s 13(2) MHA 1983, including “all the circumstances of the case” which could encompass any relevant factors. The AMHP provides an independent decision (DoH 2015) which from my analysis in this review has given rise to accountability being identified as a theme. Both found themes are infused with morality.

A national survey identified ninety-five percent of AMHPs are social workers (Skills for Care 2022). One commentator viewed social work as moral engagement, emphasising the way social workers connect with other people, “what matters is not only what we know, but what we *are*” (Whan 1986, p.246). His paper argued social work is more than technical

knowledge, with the essence of the helping relationship being moral engagement and the moral relationship. This reaches beyond professional values, merging with the personal domain. Starting with Aristotelian *phronesis*, which he described as being concerned with judgements about what is good (Whan 1986), he argued that to determine what is good for another we must reach beyond ourselves to understand the other person, representing the enactment of moral knowledge (Whan 1986). Chu et al. (2009) highlighted the intersubjective nature of such moral decisions, created *between* the social worker and service user, and motivated by the commitment to social justice that characterises the social work profession. Another author of social work practice constructed risk as a moral issue (Stanford 2011). In her study she identified how risk became infused with the social worker's personal identity, with moral dilemmas being resolved on a personal level (Stanford 2011). I have defined morality in this light, with the literature supporting the notion that AMHPs from all eligible professions studied merge their personal and professional domains, using themselves to build an understanding of service users when making detention decisions.

While the ultimate decision rests with the AMHP when two medical recommendations are made, the opinions of the doctors in the assessment process are likely to influence the AMHPs decision-making. At the point of referral for an MHA assessment this will not be the case, though invariably there will be other professionals often including doctors that will hold a view about the necessity for an assessment. Therefore, while the influence of others will have a role in decisions to proceed with an assessment, their role is not defined in law and the AMHP retains sole legal responsibility for the decision. This fundamental difference in context justifies research, and as a practising AMHP making these decisions regularly I felt the absence of research in this area contributed to a sense that perhaps this decision is not important, or indeed perhaps it does not exist? Yet I believe from practice it does, and this is something I have drawn attention to in this thesis.

In this structured narrative literature review I have addressed the search question: what is known about the factors that influence AMHP detention decisions under the MHA 1983? Many of the factors related to that decision may be highly relevant to the decision to proceed with an assessment. There may be differences also, and so the comparison of the results of this literature review with the results of the research in this thesis have provided an opportunity to compare and analyse those differences. I will begin with an explanation

of the search strategy and rationale followed by an account of the type of review conducted and a discussion of the found themes.

3.3 Methods

3.3.1 Search strategy

I have applied a start date of 1983 to reflect the introduction of the ASW role, and an initial end date of 22nd January 2020 was applied to coincide with the time of the analysis leading to my published review. Prior to thesis submission I extended the end date to 1st October 2022 to capture any subsequent literature published. Papers relating to roles like the AMHP in other jurisdictions with different mental health laws, such as the Mental Health (Northern Ireland) Order 1986 and the Mental Health (Care and Treatment) (Scotland) Act 2003, may have been a valuable source for this review topic, however they were excluded because there are differences in these legal frameworks with unknown influences on decision-making.

I conducted an EBSCOhost database search using Boolean operators. Only peer reviewed academic papers were included to enhance the possibility that the sources would be trustworthy having received validation by experts in the field. This rationale was extended to include doctoral theses. I used the following terms: “Approved mental health pr*” OR “approved social work*” AND TI/AB “decision making” OR decision-making OR deciding OR decision# OR uncertainty OR risk OR experience# OR complexit*. I included the terms *uncertainty*, *risk*, *experience* and *complexity* due to their prevalence in the literature during the initial exploration phase.

This initial search returned eighty results which reduced to seventy once I removed the duplicates. The search question contains two main elements: the AMHP role and detention decisions. Many results related to one of these elements but not both and accordingly I excluded forty-six papers where this was clear. Five papers relating to legislation outside of England and Wales were excluded. One paper, published from a doctoral thesis, was already included and therefore was not used as it was less comprehensive (Stone 2019). I adopted Wallace and Wray’s (2011) critical reading tool for the remaining eighteen papers, with a critical synopsis undertaken for each to help scrutinise their quality and relevance (see appendix one for an example critical synopsis), resulting in the exclusion of a further three papers (see Table 1), leaving fifteen papers for review.

Table 1: Excluded texts from synopsis

Text	Reason for exclusion
Beckett, C., 2009. Editorial: The ethics of control. *Ethics and Social Welfare*, 3 (3), 229-233.	Introduction to a special issue of the journal on the ethics of control so while comment is made on relevant included texts there is no additional analysis to justify inclusion.
Marriott, S., Audini, B., Lelliott, P., Webb, Y., and Duffett, R., 2001. Research into the Mental Health Act: a qualitative study of the views of those using or affected by it. *Journal of Mental Health*, 10 (1), 33-39.	Eighty-two participants only ten of whom were ASWs, with results generalised so ASW views cannot be isolated.
Webster, J., Hatfield, B., and Mohamad, H., 1999. Assessment of parents by approved social workers under the Mental Health Act 1983. *Practice*, 11 (2), 5-18.	Mostly quantitative, interview data largely absent, no overt discussion of decision-making.

I conducted a search of the British Library e-theses online (EThOS) for additional United Kingdom doctoral theses using the term 'mental health act assessment'. This returned ninety-two theses, eighty-nine of which did not relate to both main elements of this literature review. Three had relevance, two of which were already included (Stone 2017; Abbott 2018); however, one further thesis was identified for inclusion (Skinner 2006). Through reference harvesting I identified a further five papers and two books (Sheppard 1990; Peay 2003) which although not peer reviewed were cited many times by other authors strengthening their credibility. A key author search returned another one paper and one thesis resulting in a total of twenty-five texts (so named hereafter due to the inclusion of papers, theses and books) for inclusion (see Table 2).

Prior to thesis submission I repeated the EBSCOhost database search on 1st October 2022, returning 81 results, 78 once duplicates were removed. Following review of the additional texts and a critical synopsis of those seeming relevant three further studies were included at this stage. I included one further doctoral thesis following a further search of the British Library e-theses online (EThOS) on 1st October 2022. This thesis (Brammer 2020) was available for view from 26th October 2022. This increased the total to twenty-nine texts. Of note, two published articles from included doctoral thesis were not included because they did not add anything additional to the thesis in relation to ASW/AMHP detention decisions (Vicary 2021; Abbott 2022). See appendix two for a detailed list of the search results from 2022, including reasons for any exclusions.

Table 2: Included texts

Initial Search	Abbott 2018; Buckland 2016; Campbell 2010; Dwyer 2012; Gregor 2010; Hall 2017; Haynes 1990; Morriss 2016; O'Hare et al. 2013; Sheppard 1993; Smith 2001; Stone 2017; Thompson 1997; Vicary 2017; Yianni 2009.
British Library EThOS	Skinner 2006.
Reference harvesting	Fistein et al. 2016; Glover-Thomas 2011; Kinney 2009; Peay 2003; Quirk et al. 2003; Sheppard 1990; Thompson 2003.
Key author search	Glover-Thomas 2018; Quirk 2007.
1st October 2022 search update	Brammer 2020; Bonnet and Moran 2020; Rooke 2020; Karban et al. 2021.

The literature relating to AMHP decision-making is diverse; many texts include aspects of decision-making that are peripheral to the focus of the paper, and where decision-making is discussed the context differs making comparison between these texts more interpretive. Applicable texts include published empirical studies (12); empirical studies as doctoral theses (6); empirical studies published as books (2); and theory papers (9). The gains achieved by increased content for analysis may be limited by the lack of empirical foundation in some of the texts I have included.

3.3.2 Type of review

I selected a narrative literature review since it captures the relevant data woven into a complex body of literature (Collins and Fauser 2004). It was clear as I built my search strategy that literature about the AMHP role was not restricted to published empirical studies, and so the broader inclusion strategy offered by a narrative review suited the literature better. I adopted systematic methods to provide transparency to the search methods in order to make the review reproducible (Collins and Fauser 2004). This included refining my search terms to ensure relevant texts could be captured in one search. Given the inclusion of theory papers Paré et al. (2015) suggested the review is *structured* rather than *systematic*, enhancing the quality of the review. The structured methods adopted aided transparency and ensured others could replicate the search, while the narrative nature of the review was inclusive of non-empirical published materials to reflect the diversity of the literature. Whilst my experience as a practitioner in the field may have influenced my selection of included texts, the structured methods adopted and

transparency in the selection process have gone some way toward redressing bias. Additionally, I adopted Wallace and Wray's (2011) tool for determining the suitability of a text for inclusion in the review, including a critical synopsis of each possible text to develop a clear judgement about whether a text had sufficient relevance to the review question, with a more detailed analysis completed for the remaining key texts once I had made this judgement. Selecting the suitability of a text was interpretive and subjective, but adopting these tools assisted me to be clear about the quality of each text and how it related to my search question, then further assisted me to construct a coherent rationale for inclusion or exclusion that would enhance the transparency and validity of my interpretation. What follows is a discussion of the themes arising from this detailed analysis.

3.3.3 Thematic analysis

My thematic analysis was based on the original twenty-five texts included in this review, with the four added texts in 2022 being incorporated into the already developed themes.

I coded all references to factors that influence AMHP detention decisions from the data based on my critical analyses completed for each text (Wallace and Wray 2011). I then grouped codes to reflect patterned responses and I developed overarching themes to capture the essence of these codes (Braun and Clarke 2006) (see appendix three). I used thematic analysis to seek patterns in these data (Braun and Clarke 2006), a necessarily interpretive process that is likely to have been influenced by my experience as an AMHP. I identified risk, accountability, and morality as dominant themes, with morality infusing all themes. I also identified sub-themes of emotions, intuition, uncertainty, coercion, and alternatives.

3.4 Dominant Themes

3.4.1 Risk

Sheppard considered the implicit risk criteria for detention to be central to the ASW role (Sheppard 1990). His research spanned twelve-months and 120 referrals for assessment. He conducted semi-structured interviews with nine ASWs, adopting a risk analysis methodology. His focus was on the assessment of risk by ASWs, rather than risk arising from his research, as a theme. It is likely Sheppard (1990) drew on his experience as an ASW, and that his research was an attempt to answer questions arising out of his practice experience. To this end Sheppard's (1990) study was an attempt to "increase social work knowledge [and] …produce something of use to practice" (Preface), and he developed a

tool entitled the ‘Compulsory Admission Assessment Schedule’ (CASH) to aid ASW decision-making. While Sheppard (1990) conducted empirical research to inform this tool, he published his study as a book illuminating his intentions for practice development rather than academic rigour. In 1993 Sheppard published a study testing the use of CASH in practice, and together these two studies form two parts of Sheppard’s whole narrative on the topic.

Sheppard (1990) highlighted the interpretive nature of risk decisions, subject to variation between ASWs, and he focussed on the notion of a threshold of risk, beyond which detention may be justified. The subjective nature of risk hints toward the personal domain because not all people from the same professional group with the same training made the same decisions. This was also central for Peay (2003), who found variable levels of tolerance of risk between participants. Her study was commissioned by the DoH at a time of legislative reform, taking place in 1998/9 at the same time the Richardson Committee was set up to review the MHA 1983. Jill Peay, a barrister and professor of law formed part of that review and her study sought to understand the workings of the 1983 Act. Like Sheppard, Peay published her study as a book, with a focus on a practical understanding of the application of the law. She examined how forty psychiatrists and forty ASWs made detention decisions together, adopting a vignette methodology using a hypothetical case video and notes. Many of her conclusions are generalised across the participants, her theoretical stance is critical toward the legislation, and her use of a hypothetical scenario may have impacted the results albeit she offers a reasonable defence against these potential limitations. Peay (2003) also found ASWs generally wanted to get to know the person more fully prior to deciding about detention, despite being provided with a lot of written information about the person, suggesting a desire for a more personal connection and therefore introducing a moral dimension.

Similarly, Quirk et al. (2003) found a greater knowledge of the person being assessed raised the tolerance of risk by ASWs. This observation extended beyond mere information to a more holistic understanding of the individual based on a relationship with them. Their study was also commissioned by the DoH at the time of the Richardson Committee review of the MHA 1983, their remit being to explore geographical variations in MHA 1983 admissions. The principal researcher was Alan Quirk, a research sociologist with the Royal College of Psychiatrists. They published academically with the intention to inform administrators and policy makers. They carried out a participant-observation fieldwork

study spanning fourteen months with twenty assessments being observed in five teams across two London boroughs, one inner-London and one outer-London. Data were analysed using a grounded theory approach. The study was observational and therefore captured ASW practice first-hand. More recently Karban et al. (2021) further validated the dominance of risk in detention decisions, yet they highlighted the importance of getting to know the person to consider more collaborative interpretation and management of risks. Karban et al. (2021) explored how AMHPs understand and apply the social perspective. The authors were involved in delivering an AMHP programme at a university, and they recruited twelve social workers who had previously attended their programme to participate in semi-structured interviews subjected to iterative thematic analysis. Together the findings from Sheppard (1990), Peay (2003), Quirk et al. (2003), and Karban et al. (2021) begin to suggest risk does not stand alone, but that AMHPs morally engage with the person being assessed to form situated risk constructions.

Stone (2017), himself an AMHP, identified that *lack* of knowledge of the person being assessed lowered the risk threshold. He also undertook a vignette study adopting the same case video used by Peay (2003), conducting semi-structured interviews with ten social work and ten nurse AMHPs once they had viewed the video. Understanding of risk assessment was the premise of Stone's (2017) study rather than risk arising from the data. Results may have been affected by his sample given the AMHP role still comprises ninety-five percent social workers despite being opened to other, non-medical professionals (Skills for Care 2022), however his intention was to compare professional groups. Stone's participants talked of decisions being based more on feelings than information (Stone 2017), indicating a personal connection. Stone additionally found risks were interpreted subjectively by AMHPs (Stone 2017), but contrary to Sheppard's (1990) desire to standardise practice Stone (2017) advocated for the co-construction of risk with service users, particularly in circumstances where the AMHP knows the service user. Simon Abbott, another AMHP practitioner researcher sought to explore how AMHPs apply the law in practice during assessments for compulsory admission (Abbott 2018). He carried out semi-structured interviews of eleven social work AMHPs, therefore excluding other professional groups, providing rich descriptions of case stories which he analysed through framework analysis. All included case stories related to assessments that resulted in detention, which may have given rise to a bias in the results. He echoed Stone's (2017) recommendation, suggesting AMHPs should give "equal prominence to the voice of the person being assessed" (Abbott 2018, p.180). These recommendations were made on the basis that these factors are not

currently influencing detention decisions. To what extent this is the case cannot be generalised, but it is interesting to contemplate how these factors might influence detention decisions. I have considered how these factors have influenced decisions at the point of referral for an MHA assessment in this thesis.

Nicola Glover-Thomas, a professor of law also identified the significance of knowledge of the person being assessed (Glover-Thomas 2011). She sought to establish whether the legal framework amplified risk, and she adopted an affirmative bias which is supported by her research findings and references to wider literature. She interviewed AMHPs, psychiatrists and former clinical administrative staff then making policy decisions. She did not give detailed participant information or sample size, nor did she discuss her methodology. She identified that participants had a lower risk threshold for detaining people unknown to the service (Glover-Thomas 2011). Peay (2003) also found evidence in support of this, with ASWs generally wanting to gather more information and to get to know the person better prior to deciding about detention. All these studies, using a range of methodological approaches biased by focus, theoretical stance or methodological vagaries, nevertheless provide a consistent finding for the value of knowing the person when assessing risk in the context of detention decisions, one aspect of moral engagement where an understanding of risk may emerge through a personal connection.

Yet, Glover-Thomas (2011) also identified clinical history as prejudicial, supported later by Abbott (2018). However, the seeming contradiction regarding the impact of knowing clinical history could be explained by the role of morality in these decisions, where risks may be constructed on a personal level and are therefore subject to more than technical judgements.

These findings offer valuable insights into what might influence the decision to proceed with an assessment following a referral for an MHA assessment, my interest in this thesis. Building on Sheppard's (1990) identification of a wide threshold of risk, which suggests the significance of subjectivity in decision-making, Peay (2003) confirmed Sheppard's (1990) position but also offered one avenue for explanation of this variability, namely the desire for greater knowledge of the person. Quirk et al. (2003), Glover-Thomas (2011), Stone (2017), and Karban et al. (2021) all validated that this raised the threshold of risk, and it would seem logical for this position to be replicated at the point of referral where knowledge of the person would impact upon the decision about whether to proceed with an assessment or not. What I have illuminated in this thesis is what happens where little

information is available about the person being referred. The research suggests detention becomes more likely with less knowledge, so does this mean less knowledge at the point of referral leads to a decision to carry out an MHA assessment? This would seem counter-intuitive, and following Peay (2003) a desire to obtain more information may apply, yet how do issues of risk then impact upon this desire? These variables have been of crucial interest to me in this thesis.

Sheppard's (1990) study identified that many ASWs focussed on the patient's mental health, conflating mental illness with risk. This propensity to use a medical approach repeats: O'Hare et al. (2013), identified the use of medical dialogues. A collaboration between four social work academics with previous experience as ASWs, O'Hare et al. (2013) set out to consider the impact of policy developments upon ASW/AMHP practice. Case vignettes were used alongside a postal questionnaire which was thematically analysed. Just three ASWs from England and Wales participated in this study (others hailed from different legislative contexts, were student social workers, or AMHP or equivalent trainees), and their conclusions were generalised thereby reducing the applicability of this study to the current review question. Buckland (2016) found her participants located treatment in hospitals. Rosie Buckland, herself an AMHP, carried out semi-structured interviews of ten AMHPs focussing on a recent memorable assessment for them using Foucauldian discourse analysis, a methodology biased toward power imbalance. She found medical narratives being utilised by AMHPs to justify detention (Buckland 2016). It is notable that Buckland's study took place twenty-five years after Sheppard's (1990), highlighting the pervasiveness over time of this influence if these studies are to be deemed representative.

Peay (2003) found the contrary; that ASWs spoke more from a social rather than medical perspective, whilst Hall (2017) found that ASWs understood crises in social terms. Peter Hall is a former ASW who completed a doctoral thesis related to ASW practice. His thesis being unavailable does not form part of this review, but he later published from this thesis and this paper is an included text. Hall (2017) interviewed service users, ASWs and home treatment professionals involved in nine MHA assessments using framework analysis. Hall's (2017) study was biased toward assessments resulting in home treatment rather than detention, which may have impacted results. He also found ASWs used socially oriented language (Hall 2017) thereby contradicting Sheppard (1990), O'Hare et al. (2013), and Buckland (2016), yet consistent with Peay (2003), suggesting methodological influences, or

individual or local operational differences. With some studies highlighting the prominence of social perspectives and some highlighting the prominence of medical perspectives this suggests influences beyond the application of professional values, with personal values being one alternative explanation for the difference.

Brammer (2020) offered a unique interpretation on risk and medical perspectives based on the findings from his study. Andrew Brammer, an AMHP himself, carried out a qualitative study into factors relevant to AMHPs when considering applying mental health legislation. He conducted eighteen semi-structured interviews about a case vignette, then facilitated a focus group with seven different AMHP participants, analysed from a critical realist perspective. He identified that AMHPs accepted a reality of mental distress, but they sought to establish a causal link between the mental distress and arising risks in order to justify the use of mental health legislation (Brammer 2020). As such risk was not viewed as inherently relating to mental illness, so while medical perspectives were prevalent this did not translate directly into an increased likelihood of detention.

The implication from Sheppard (1990), O'Hare at al. (2013) and Buckland (2016) is that a medical orientation is more likely to lead to detention than a social orientation, however Abbott found this was equally true of a social orientation (Abbott 2018). Of note, Abbott (2018) found

> "the social and family situation of the person assessed, combined with views of others, and particularly the impact of risk on others, is the most influential factor in the decision to detain" (p.5).

This suggests like Hall (2017) that Abbott's (2018) AMHP participants adopted a more socially oriented perspective. Abbott (2018) further identified that AMHPs had a desire to contain risks through detention in hospital, with decisions "dominated by feasibility arguments" (p.123). Bonnet and Moran (2020) offered further support for this finding, citing the ability of community teams to manage risk as influential to the detention decision. Their study sought to understand AMHP perspectives on why detentions are rising in the context of the independent review into the MHA 1983, and the future potential for legislative reform. Key to the research was whether legal reform is the appropriate response to address the high rates of detention. A mixed-methods study design was adopted, combining an online survey of 160 respondents and six semi-structured interviews, subject to framework analysis. What Abbott (2018) and Bonnet and Moran (2020) highlight is the possibility that both medical and social discourses on risk can

equally lead to a decision to detain. In Sheppard's (1990) study of 120 assessments there were only ten occasions where ASWs disagreed with psychiatrists, and Sheppard (1990) suggested this was unsurprising given the mental health orientation adopted by ASWs. Abbott's (2018) study appears to suggest that even when ASWs adopt a social risk orientation as defined in Sheppard's (1990) study, the degree of disagreement may not be affected. The findings in Abbott's (2018) study may point to methodological differences, particularly when some of his findings echo Hall (2017) and both used framework analysis, but equally both positions could be representative of AMHP decision-making. Sheppard (1990) viewed these positions as mutually exclusive, yet in the same way Glover-Thomas (2011) highlighted less information lowered risk thresholds while at the same time clinical history was prejudicial, it seems such contradictions could arise in other aspects of the decision. As I will highlight later in this review, contradiction and uncertainty dominate the decision to detain, and so medical and social narratives being adopted to inform AMHP decisions seems possible, if not likely. Where a decision to detain is made between three professionals, an AMHP and two doctors, the presence of medical discourse in the AMHP's account is unsurprising; what has not been addressed in the research is how much of an impact medical discourse has on decision-making at the point of referral for an MHA assessment.

Sheppard (1990) identified a lack of clarity between what is understood by hazards, dangers and risks. It was this lack of clarity that affected the threshold of risk, which he concluded led to variable outcomes (Sheppard 1990). Under similar circumstances some ASWs felt the risk threshold for detention was met where others did not, a finding echoed by Glover-Thomas (2011) who noted that participants could not define risk but viewed it as self-evident, while O'Hare et al. (2013) felt participants had an "arbitrary understanding of risk" (p.200).

Sheppard (1993) developed a decision tool to attempt to address subjectivity and poor clarity, which he later tested among five ASWs undertaking over seventy-one assessments, adopting an action research methodology. He found that consistency and clarity were both improved from using the tool (Sheppard 1993). Glover-Thomas (2011) also sought some way of standardising risk assessment; however, she found her participants wanted professional discretion over risk (Glover-Thomas 2011). That decision tools have not become widely used by AMHPs making detention decisions arguably supports the interpretive nature of detention decisions.

Sandra Dwyer, a former ASW, wrote an article to illuminate the experience of AMHP practice. Of the MHA assessment itself, she indirectly cited Bion stating the assessment is "the opposite of a situation conducive to thinking" (Dwyer 2012, p.345), by which she was referring to the chaos of the assessment process. While the point of referral for an MHA assessment may also be fraught, there may be a distance from the situation giving rise to the request at the time. As such a question answered in this thesis was whether decision-making at the point of referral for an MHA assessment has any greater chance of clarity than the detention decision.

Closely aligned to risk in my analysis of the literature in this review is accountability, where the focus of risk concerns the consequences for the individual AMHP given the independence of their decision (DoH 2015).

3.4.2 Accountability

Skinner (2006) found that professional liability was a significant factor in detention decisions. Laura Skinner, completing a clinical psychology doctorate in 2006, sought to understand the experience of ASWs, senior nurse practitioners, and psychiatrists carrying out MHA assessments, using grounded theory. She interviewed eleven participants from one geographical region, seven of whom were ASWs. Peay (2003) identified the decision to detain is driven by fear of the consequences of not detaining in relation to risk. Risk then may not stand alone as a factor in detention decisions, rather it is the willingness of the AMHP to take responsibility for the consequences arising from those risks that may be decisive. Of course, in detention decisions accountability only rests with the AMHP where two medical recommendations have been made, so prior to this there is an opportunity to share the statutory responsibility for the decision, something that is not possible in the same way at the point of referral.

Quirk et al. (2003) found that peer support reduces the likelihood of detention. Skinner (2006) also supported this position, identifying that uncertainty about organisational backup "manifested in cautious practice" (p.103). Gregor (2010) found ASWs experienced stress from their responsibility in being required to make detention decisions. Claire Gregor, a practising ASW interviewed twenty-five ASWs using grounded theory, focussing on how they related emotionally to the role. ASW detention decisions were ancillary to her study, but she found working in a supportive team was valued (Gregor 2010). So, support from professionals not directly involved in the assessment may have a direct impact upon

the AMHP's willingness to take responsibility for the risks. If representative, this finding is likely to have relevance to decisions at the point of referral also because it suggests that a statutory role in the decision is not a critical element to minimise the impact of accountability on decisions.

Kinney (2009) explored the ethical issues involved in the detention process, contending that, in the face of two medical recommendations for detention, promoting autonomy is ceded to concerns about accountability for risk-taking. Written from his experience as a practitioner, Kinney's (2009) theoretical paper was biased toward issues of power, oppression and anti-discriminatory practice. He, crucially, proposed that at the same time as being accountable for the risk-taking, AMHPs have little power to influence risk-taking in less controlling ways, leading to ethical compromise (Kinney 2009). Risk and accountability may then present moral conflict where alternatives are unavailable. Brammer (2020) equally confirmed this supposition.

O'Hare et al. (2013) hypothesised a risk averse climate where future risks are overestimated. Buckland (2016) supported this, with all her participants linking public discourses on risk to defensive risk averse practice due to personal accountability. Quirk et al. (2003) identified the impact of the 'blame culture', with a detention decision being favoured to avoid censure. Bonnet and Moran (2020) observed the tolerance for risk among community teams was low. Organisational culture may then influence detention decisions through the AMHP's perception of accountability (whether real or imagined).

Fistein et al. (2016) identified that practitioners feared accountability for a person's future behaviour. Elizabeth Fistein, a psychiatrist, lawyer and academic sought in her doctoral study to describe how decisions to detain are made in practice where a tension between policy and practice has been identified. Her thesis was unavailable for this review, but she published a paper reporting on her study which is included (Fistein et al. 2016). They took a mixed-methods approach adopting an institutional ethnography in their observation of discussions between medical practitioners and AMHPs, following assessments. This they combined with individual narrative interviews with those practitioners using a biographical narrative interpretive methodology. Their study involved a limited number of AMHP participants: while five AMHPs were involved in the observational component only one AMHP was interviewed individually. Nevertheless, this finding is consistent with wider research. In a later paper Glover-Thomas (2018) theorised that a fear of adverse consequences influences detention decisions. She related this to case law in relation to

human rights challenges regarding the right to life and the right to liberty. The direct relation to litigation suggests an implicit link to accountability.

Interestingly, Abbott (2018) identified accountability in a different light. In his study under the theme of relationships and resources he used the term autonomy, something which was valued by the AMHPs participating in his study. What Abbott (2018) concluded was that AMHPs value the potential to disagree with the doctors, even if they agree. Accountability then, or autonomy, may lead to risk averse decisions or may liberate the AMHP from medical opinion and provide them with the freedom to agree or disagree. These apparently conflicting perspectives may be mutually exclusive, or possibly they operate simultaneously on different levels for the AMHP. This dichotomy links closely to the findings of Vicary (2017) and is discussed further under the morality theme.

I suggest these findings unite risk and accountability in detention decisions, underpinned by notions of morality and moral conflict.

3.4.3 Morality

Quirk (2007) included additional analysis on an earlier study conducted by himself and colleagues (Quirk et al. 2003). He found different

> "ideological or philosophical orientations to mental health care will influence decisions to section and this will have resource implications" (Quirk 2007, p.286).

He proposed the resources made available to provide alternatives to admission are crucial to the detention decision, making the institutional context of direct relevance (Quirk 2007). Quirk et al. (2003) established that organisational culture operates on a team level, finding local operational norms in some geographic areas that promote detention as a last resort, while in other areas with less resources there was a sense of pragmatism favouring detention. Arguably, a moral position that supports detention as a last resort contradicts a moral position that views detention as pragmatic, suggesting that organisational culture may influence individual moral positions.

It is noteworthy that few studies have reported on the influence of organisational culture and operational norms, though Quirk et al.'s (2003) study was one of only two fieldwork observational studies included in this review, the other being Fistein et al. (2016), and not including Peay (2003) which though seeking to replicate a realistic scenario was nevertheless fictitious. Recognising organisational and operational factors may be more difficult to achieve with the other research methodologies used in the included studies.

This presented a challenge to how any such influences could be captured if present at the point of referral for an MHA assessment.

Kinney (2009) provided an example of detention in the absence of alternative resources leading to his sense of personal failure, a direct acknowledgement of the personal domain. For Kinney (2009) the morals of his organisation were at odds with his own, a position far removed from pragmatism. He concluded the main resource in an MHA assessment is the AMHP themselves (Kinney 2009), one aspect of moral engagement.

Dwyer (2012) commented that the detention process “can feel like a barbarity” (p.350), suggesting moral conflict operates internally rather than clashing with organisational values. Her stark emotional response to detention highlights the decision is made on a personal as well as a professional level.

Quirk (2007) explored the notion of *dirty work* in relation to the ASW role, where perhaps moral conflict might have been expected if a clash in organisational and individual morals were present. *Dirty work* was a term coined by Hughes (1971) to refer to morally dubious work. This concept directly bridges the personal and professional domains. While the ASW role as *dirty work* was acknowledged by participants in the study, a more prominent perspective was one that viewed detention as helpful to people (Quirk 2007).

The notion of *dirty work* was explored further by Morriss (2016a), a published paper arising out of Lisa Morriss’ doctoral study. An AMHP herself, Morriss (2016a) conducted narrative interviews with seventeen practising social work AMHPs analysed using dialogical narrative analysis. She purposefully selected social workers excluding the influence of other AMHP professional groups, possibly affecting her results. She found social work AMHPs recognised the negative impact of admission, particularly that wards can be dangerous (Morriss 2016a). The risk of admission was highlighted earlier by Smith (2001), himself a practising ASW who in a theory paper reflecting upon risk assessment in ASW practice, highlighted the risks to self-esteem, harm from treatment and harm from others when in hospital. Kinney (2009) similarly highlighted concerns about the risk of admission, both in terms of the environment and the negative impact of treatment and labelling. Morriss (2016a) linked the potential harm caused by admission with the “contradiction inherent in AMHP work” (p.713), where the negative consequences of detention are balanced against the perceived reduction in harm to the person. Brammer (2020) similarly found the harm of admission was considered in the balance. Skinner (2006) explored this issue,

conceptualising the ethical dilemma as an internal conflict where cognitive dissonance is generated. She found support for the control to care rationalisation to resolve this internal conflict, equally espoused by Yianni (2009), a former ASW reflecting on the ethics of ASW/AMHP practice in his theory paper, and Buckland (2016). Such a shift suggests morality is pivotal in detention decisions, where AMHPs may shift their personal moral position as a way of rationalising their role. Additionally, Buckland (2016) identified the importance of personal values which differed between participants, a direct reference to a moral dimension.

Rachael Rooke, a practising AMHP and academic, wrote an opinion piece that is the closest I have found to an exploration of decision-making at the point of referral for an MHA assessment, albeit she offered her considerations as an early intervention to avoid a full assessment in situations where risks are low (Rooke 2020). Her emphasis was on meeting the person referred to work collaboratively and transparently with them to avoid a full assessment and detention (Rooke 2020). Other than Rooke (2020), the literature does not address is how AMHP value positions might affect the decision to proceed with an assessment. Additionally, there may be value positions on the impact of the assessment itself on the person being assessed. In this thesis I have sought to explore these issues which remain hidden at present in the experience of the individual practitioner. Abbott (2018) used the analogy of a football game to highlight even from the point of referral for an MHA assessment a range of stakeholders have an expectation of detention. Accepting this position, it is easy to see how the further the AMHP takes the referral toward a full assessment the closer the likelihood of detention becomes, so arguably the decision to assess becomes more critical than the decision to detain.

Fistein et al. (2016) found some support for the rights-based perspective, identifying that participants favoured ‘soft paternalism’, where decisions were based on the best interests of the person being assessed. For Fistein et al. (2016) moral conflict only occurred with ‘hard paternalism’, where the risk of harm to others was the principal driver for the detention decision. In his theory paper Campbell (2010), a former ASW, highlighted the impossibility of AMHPs balancing the competing expectations of the person, their family, and the public.

Peay (2003) observed that ASWs became less sure about detention after watching the case video, indicating a greater degree of connection with the individual after seeing them. Dwyer (2012) supported the person-centred nature of AMHP practice, as did Vicary (2017)

who found support for a positive focus on the person being key to AMHP practice. An AMHP practitioner researcher, Sarah Vicary (2017) conducted semi-structured interviews including the drawing of rich pictures with twelve AMHPs, comprising five social workers, five nurses and two occupational therapists as part of her doctoral study. This purposive sample is not representative of the AMHP population given ninety-five percent of AMHPs are social workers (Skills for Care 2022). However, interpretative phenomenological analysis seeks an understanding of a phenomenon, in her case how the role was experienced between professional groups. She identified that positive feelings translated into action, with AMHPs defending the person being assessed from the negative views of others, conceptualising this as a moral concern for others leading to moral action, and identifying this as enacted personhood (Vicary 2017).

Vicary (2017) did not explicitly link personhood to decision-making, but in her results the examples she gave from her participants support an intrinsic link, with issues of humanisation, rights and non-judgemental practice offering insights into how her participants interpreted people's lives in the process of forming opinions about the necessity for detention. In Vicary's (2017) participant quotes there were examples of positive regard for people that the AMHP had not met yet as well as those they had assessed under the MHA 1983. This is an important finding with respect to this thesis, because it is likely that at the point of referral for an MHA assessment the AMHP may not have met the person being referred for an assessment. While Peay's (2003) study highlighted there may be a desire at the point of referral for an AMHP to get to know the person, Vicary's (2017) findings suggest personhood may be enacted without meeting the person. The role of personhood in decisions at the point of referral for an MHA assessment has not been researched, but this would seem to have the potential to have some influence; to what extent and how this thesis has established.

As referred to under the risk theme, Hall (2017) found AMHPs viewed situations at the point of an MHA assessment as social crises. This was relevant to the risk theme because together with Abbott (2018) it offered a contrary position to the other literature in which ASW/AMHPs adopted more medical narratives, however the position is one predominantly of values, where an understanding of the person's social situation takes primacy. What Abbott (2018) went on to establish however was that this did not necessarily affect outcomes, with detention being equally likely whether a social or medical perspective was adopted. One contributory factor in Abbott (2018) was that greater weight was given to

accounts from family members than the person being assessed themselves, and the rights of family members were prioritised. This seems inconsistent with Vicary's (2017) findings in relation to personhood and adds a further dimension to the potential value positions adopted by AMHPs in making decisions about detention. Abbott's (2018) finding is of interest to decision-making at the point of referral for an MHA assessment where often the views of family members may be obtained in advance of the AMHP having contact with the person being referred for an assessment; indeed, sometimes the AMHP may not have contact with the person being referred if an assessment does not proceed. The views of the family may then be pivotal to a decision to proceed with an assessment.

3.5 Sub-themes

I identified sub-themes that emerged from my analysis of one or more of the dominant themes. These were: emotions, intuition, uncertainty, coercion, and alternatives. I will discuss each sub-theme and link them to one or more of the dominant themes.

3.5.1 Emotions

The emotional state of the AMHP has relevance to AMHP practice and by extension detention decisions. Fatigue was identified by Haynes (1990) as a barrier to thoroughly investigating a situation and a tendency to agree with doctors. Ruth Haynes (1990) carried out a study in 1988 to examine the changes in the role from the Mental Welfare Officer to the ASW, asking participants what influenced their decision in their most recent out of hours assessment. She conducted semi-structured interviews with twelve ASWs, though she has not been explicit about her methodology. The applicability of this study to current practice must be viewed cautiously given the study took place in the early years of the MHA 1983, and particularly given all participants would have had only three weeks training in the role as was the case at the time. Subsequent literature does not mention fatigue as a factor in detention decisions, though Haynes' (1990) is the only study in this review to focus on out-of-hours assessments. A key point of relevance is that all the participants in Haynes' study worked full-time in day services, with out of hours work being carried out in addition to this on a once a week standby basis. This highlights the potential consequences of service design on detention decisions, something as applicable today as thirty years ago. Few services remain structured in the way they were in Haynes' (1990) study, but a common comparator to many modern services is the potential for an AMHP to receive a

referral at the end of their working day which if circumstances warrant it would require them to follow through the assessment until its completion, often many hours later.

Peay (2003) identified the decision to detain is driven by fear of the consequences of not detaining in relation to risk. Fear emerges from risk and accountability in this observation.

In 2003 Paul Thompson published a paper reflecting on his own experience of the ethical dilemmas experienced in the ASW role. He adopted a psychodynamic framework invoking the concept of the ASW containing mental distress (Thompson 2003). Gregor (2010) similarly identified the ASW containing the anxieties of others. Dwyer (2012) supported this concept, adding that decisions are both cognitive and emotional. So, for Dwyer (2012) the emotional experience directly impacts on decision-making, with the idea that decisions emerge rather than are reached purely cognitively. Any referral for an MHA assessment will be accompanied by a degree of concern about the person being referred, and as such the concept of being a container for the stress of others may hold relevance to this part of the process. However there potentially remains a distance between the AMHP and the crisis situation giving rise to the referral which could limit the extent to which this influences decision-making at the point of referral.

Subsequent literature has built upon the notion that AMHPs utilise emotions to perform the role and make decisions. Morriss (2016a) identified guilt about detention decisions, but that this emotion was how it should be. This was echoed by Stone (2017). Guilt is a personal emotional response reaching beyond the professional domain. This suggests that guilt may be used as a form of brake or safety catch that the AMHP employs to ensure they can justify detention decisions to themselves. Vicary (2017) introduced what she described as the feeling rule dichotomy whereby, conflicting emotions are used to control practice, so to extend Morriss' (2016a) example guilt may be used alongside pride to give due weight to a decision (Vicary 2017). Emotions may then operate as an extension to morality, moving beyond professional values and bringing the AMHP as a person closer to their detention decision.

These conclusions relate to detention decisions, where the AMHP has already immersed themselves in the situation and positioned themselves as a key individual to offer a resolution. The context of the decision at the point of referral for an MHA assessment has fundamental differences, with the AMHP either being more distant from the situation, or even when they meet the person being referred, they do not come with detention as an

immediate option. The impact of emotions on decision-making may be less pronounced in these circumstances, but this is something that has not attracted any research to date, a gap I have addressed in this thesis.

3.5.2 Intuition

The emotional concept of the 'right decision' arose in some studies (Dwyer 2012; Buckland 2016; Morriss 2016a), with Stone (2017) offering the fear of the 'wrong decision' as pervasive. The terminology used supports this may be more of an internal concept, with the focus being on feelings rather than objective truth. Dwyer (2012) used the term 'emerges' to describe decision-making, which together with the use of feeling terms supports a link to intuition. Kinney (2009) referred to suspicions and feelings about what needed to happen, while Glover-Thomas (2011) concluded factors were filtered through intuition to reach a decision. Fistein et al. (2016) interpreted decisions based on a prediction about treatability to be based on intuition. Stone (2017) found support for intuition affecting decision-making, commenting this was difficult for participants to articulate. Buckland (2016) found participants used the term 'common sense' to describe their decision-making, invoking bodily metaphors to describe decisions. The literature supports that the AMHP intuitively uses themselves as a resource in decision-making, by extension integrating intuition with morality.

The related concept of practice wisdom arose in some studies (Dwyer 2012; Vicary 2017; Stone 2017; Brammer 2020). Peay (2003) may have found some support for the role of intuition in her observation that among ASW's initial impressions were pervasive, and confidence increased with more information. Peay (2003) did not interpret this finding as intuitive, but this explanation seems compelling given the subsequent research. Of intuition Peay (2003) did however comment that

> "discussions about 'law' were often ill-informed or based on an intuitive understanding, which was not necessarily correct" (p.29).

Abbott (2018) was more sympathetic to intuition in his thesis, providing a well-constructed case for the embodiment of law in AMHP practice, where 'law-talk' was rarely used but descriptions of practice were clearly structured by the law. Brammer (2020) supported this observation. It is possible AMHP practice improved in the intervening years between these studies, or the differences may be methodological or interpretive. The intangible nature of intuition or practice wisdom may explain its absence from much of the literature, offering a challenge for any study to capture particularly when coupled with a sense from some

participants that such factors represented a form of dirty secret (Buckland 2016; Stone 2017). The current literature does not offer an insight into whether intuition is utilised at the point of referral, yet Peay's (2003) finding about initial impressions suggests it has relevance. I have clarified the role of intuition in decisions at the point of referral for an MHA assessment in this thesis, rising to the methodological challenges inherent in seeking such clarity.

The concept of identity offers a natural progression from intuition that has been considered by some authors in this review. Skinner (2006) identified the assimilation of the process of MHA assessments into professional identity. Vicary (2017) found further support for this in her study in which she had initially sought to understand the role of professional background on AMHP role fulfilment, identifying that the role itself affected professional identity rather than the reverse, with the key concept of personhood becoming embodied by the AMHP. Stone (2017) commented on the intrinsic nature of the role borne out of "familiarity of undertaking AMHP work" (p.117). Karban et al. (2021) found the social perspective became fused with the social work identity. The role of intuition and identity highlights how AMHP detention decisions are more than technical in nature, with a blurring of influences that may emerge from the personal as well as the professional domain. These concepts are not easy to capture in research, something which I have nevertheless addressed in this thesis through adopting a methodological approach conducive to tackling the intangible.

On the fringes of intuition lies the information gathering and interpretation process conducted by AMHPs. Returning to Peay (2003) and her identification that initial impressions were pervasive, Quirk (2007) found that information from trusted sources was taken at face value, supported by Dwyer (2012) who reflected that AMHPs assess the quality of the judgement of others. Similarly Brammer (2020) identified the motivation of those referring was considered. These observations refer to early decision-making and as such are the most closely related to this thesis. Quirk (2007) reported from one participant that ASWs develop a hypothesis which they continue to test, suggesting early impressions remain under scrutiny. This position is supported by Hall (2017) who identified AMHPs constantly question their decisions. However, Buckland (2016) offered an alternative perspective from one of her participants who appeared to seek supporting evidence while disregarding contradictory information, elevating the status of research over lived experience. Peay (2003) observed that ASWs increased in confidence with more

information, which could support Buckland's interpretation or as above may be confirmatory evidence of the role of practice wisdom. Either way there is support for the importance of early decisions prior to the assessment, validating the necessity to understand decision-making at the point of referral for an MHA assessment better.

3.5.3 Uncertainty

Uncertainty was espoused as central to decisions in some of the included texts. Peay (2003) inferred risk aversion from uncertainty. Glover-Thomas (2018) equally provided a perspective that detention will be favoured by professionals where there is uncertainty. These studies support a direct link to accountability. Thompson (2003) gave a more sensitive practitioner perspective that offers uncertainty as part of the role rather than the decision itself. Skinner (2006) based her thesis on the premise that uncertainty is central to the assessment process, with Buckland (2016) concurring. These observations provide a useful context to decisions that may be as applicable to decisions at the point of referral for an MHA assessment as they are of decisions to detain.

3.5.4 Coercion

The notion of coercion being applied to AMHPs is prevalent within the literature, being first cited by Haynes (1990). In fact, her study made a somewhat indirect link to pressure, and the relevance of her findings may have been reduced with the passage of time. She identified that older GP's involved in MHA assessments

> "found it hard to accept the more assertive and independent role of the ASW, and there had been some fierce conflicts" (Haynes 1990, p.192).

Haynes (1990) referenced an ASW applying for the detention of a person in response to the demand of a GP despite the person being asleep when they tried to assess them. Such practice may have had as much to do with the newly created nature of the role as it did the pressure applied, but nevertheless the impact of pressure on the ASW in this scenario is inescapable.

Thompson (1997) reflected on a situation in which pressure from his employer impacted his decision-making. He further reflected in Thompson (2003) about an ASW feeling under management pressure to detain someone. Campbell (2010) echoed these reflections in his critical commentary, surmising that decisions are "likely to be compromised by competing organisational and resource demands" (p.332).

Such coercion relates closely to organisational culture discussed in the morality theme, and the link to accountability is implicit. Skinner (2006) found her participants reported feeling coerced, with Quirk (2007) observing that community psychiatric nurses were informally influential over detention decisions. Such external pressures outside the context of the assessment itself are of direct relevance to the context of referral decisions and therefore offer insight into the interest of this thesis. Kinney (2009) extended the influence of coercion into the assessment itself, in which he reflected on a situation with heightened anxiety from the police, doctors and the person’s husband where his desire for a holistic assessment was delegitimised and he felt pressured to implement the will of the other stakeholders. Kinney’s (2009) emotive description of this assessment captured the powerlessness of the AMHP in situations of urgent need despite their privileged position in terms of the law. Such pressure is perhaps understandable at the assessment where tensions may be raised, however Abbott (2018) highlighted “an adversarial atmosphere at the point of receiving the referral” (p.148) where he described coercion had already begun before the AMHP has become involved (Abbott 2018). This was supported by Rooke (2020), and equally Brammer (2020) found a “pressure to detain” (p.217). Conflict and pressure then apply to the point of referral for an MHA assessment, and in this thesis I have uncovered the impact of such pressure on these decisions.

3.5.5 Alternatives

Kinney (2009) conceptualised the absence of power over alternative resources as undermining the AMHP role, a position echoed by Hall (2017) in which he highlighted the ASWs only power is to detain. Hall (2017) positioned the ASW as “negotiator and deal-maker in exploring community provision” (p.453). Such a position retains some optimism. However, others have cited the limited choice of alternatives to admission as deterministic (Haynes 1990; Quirk at al. 2003; Buckland 2016; Stone 2017; Glover-Thomas 2018; Bonnet and Moran 2020; Brammer 2020; Karban et al. 2021). Quirk et al. (2003) problematised a lack of time to organise alternatives, reinforced by Kinney (2009) citing pressure to resolve a situation quickly. Karban et al. (2021) added applying the social perspective was contingent upon alternative options being available, while Rooke (2020) expressed a view that the AMHP’s satisfaction about the outcome of an assessment is influenced by what alternatives were available, similarly identified by Brammer (2020) as leading to frustration and personal conflict.

Thompson (1997) cited the willingness of the service user to work with him (as the ASW) being decisive in avoiding detention. Hall (2017) evoked the same message, with the ASW as negotiator brokering agreements with the service user, such as to work with the home treatment team. Abbott (2018) similarly found one participant was

> “willing to seek alternatives to hospital admission if the person was able to establish a therapeutic alliance” (p.119).

Abbott (2018) added the element of trust to such willingness, with AMHPs basing decisions to detain on a lack of trust in the service user to engage in community services. Here morality may be the underlying factor through the connection between the AMHP and the service user, constructing situated judgements through moral engagement. Abbott (2018) identified the importance of service users accepting they are unwell, linking this to trust in them taking medication. Stone (2017) also found concordance with prescribed medication was an important factor in avoiding detention returning to the medical perspectives discussed earlier, and with use of non-prescribed medication (substance misuse) as a factor increasing the likelihood of detention. These factors imply a necessity for the AMHP to meet the person referred for an assessment to inform an opinion about willingness, trust and the potential for therapeutic alliance. The extent to which this applies to decisions at the point of referral for an MHA assessment has not been explored in the literature and was of relevance to me in this thesis.

Thompson (1997) reflected that self-control of the person being assessed regarding potential risk behaviour was important for the viability of community options. Abbott (2018) identified risks being invoked to justify detention, and alternatives only being an option if the person being assessed is willing to adhere to the alternative plan. Key to such feasibility arguments was the ability of the family to cope with the person in the community, without which detention was sought (Abbott 2018). Alternatives to detention, then, cohabit risk and accountability and are infused with morality in detention decisions. It is likely that the views of the family will be obtained by AMHPs at the point of referral for an MHA assessment, along with consideration of the viability and feasibility of community options, however the research to date does not confirm this is the case, nor to what extent these factors influence these decisions.

At this stage it is relevant to mention the potential for an admission to hospital by means other than detention under the MHA 1983. This has become an increasingly complex area of law particularly in recent years offering some explanation for rising detention rates.

Section 131 MHA 1983 makes provision for people to be admitted informally to hospital as opposed to detained under the MHA 1983. This provision dates back to the Mental Treatment Act (1930), yet the introduction of the Mental Capacity Act (MCA) 2005, the subsequent inclusion of the deprivation of liberty safeguards into the MCA 2005 via the MHA 2007, and the caselaw arising from human rights challenges, particularly the supreme court judgement in P v Cheshire West & Chester Council; P & Q v Surrey County Council [2014] have acted to erode the possibility of informal admission for people who lack the capacity to consent. For those deemed to have the capacity to consent the Code of Practice to the MHA introduces some cautionary advice on informal admission, particularly regarding risk, possibilities the person will change their mind, or the avoidance of coercive practice (DoH 2015). Additionally, caselaw has further contributed to a move toward detention (for example Savage v. South Essex Partnership NHS Foundation Trust [2008] and Rabone v. Pennine Care NHS Foundation Trust [2012]). Interestingly, or perhaps understandably it is the lawyer authors within this review that have been most focussed in such legal intricacies, perhaps reflecting Abbott's (2018) conclusions that AMHPs tend to avoid law-talk, yet the reverse must be anticipated from legal professionals.

On the matter of detention decisions then, one alternative to detention would be informal admission to hospital. Fistein et al. (2016) found that informal admission was viewed by participants as less restrictive, however she also identified that the only case where the person was deemed to have capacity regarding their treatment was when the person readily agreed to admission, while in all other cases where the person refused admission they were deemed to lack the capacity to make treatment decisions which then justified their detention under the MHA 1983. From her study it seems a person's capacity to consent to treatment was considered important, but was conflated with their agreement. Glover-Thomas (2018) suggested a "cautionary approach adopted by clinicians to informal treatment" (p.11). She went on to highlight the impact of further caselaw on perceptions of risk, concluding "informal hospitalisation will be less attractive" (Glover-Thomas 2018, p.13). Finally, Glover-Thomas (2018) pointed to the operational benefits of detention, where the shortage of inpatient beds may contribute to detention as a means of ensuring a person is given access to services they need. Such legal and operational matters have increased the legal complexity of AMHP detention decisions, however their impact upon decisions at the point of referral for an MHA assessment have not been considered in the literature. Legal considerations may impact AMHP decision-making at this point, but gaining insight into this may offer methodological challenges if we accept, following Abbott

(2018), that AMHPs tend not to use legal language. Indeed, this much must be accepted when reflecting on the extent to which the law has featured in this literature review.

3.6 Decisions at the point of referral for an MHA assessment

Quirk et al. (2003) offered an opportunity in the context of early information gathering to digress to my key interest in this thesis, decisions at the point of referral for an MHA assessment. Quirk et al. (2003) referred to ASW's carrying out crisis visits "*to delay triggering MHA assessments until other alternatives had been fully explored"* (p.124 [original emphasis]). Alternatives to admission then are a key consideration before an assessment is convened. Glover-Thomas (2011) similarly commented that "often other steps are commonly taken before using the Mental Health Act" (p.602), however she went on to describe this as operating in a non-legal sense. In Quirk's (2007) later thesis he observed that

> "much informal assessment and case construction can occur during the planning of the assessment… to such an extent that professionals carry into the assessment a clear expectation of the likelihood of compulsory admission" (p.265).

Quirk (2007) also made the point that this can sometimes lead to the assessment being cancelled. Quirk's terminology is of interest, particularly his description of the information gathering process being 'informal', which together with Glover-Thomas' (2011) description of events pre-assessment as 'non-legal' appears to be a direct reference to the subject of this thesis, yet rather than acknowledging the statutory basis of such decision-making within s 13(1) MHA 1983, Quirk (2007) and Glover-Thomas (2011) consider these decisions being made outside of any statutory framework. In this thesis I offer a direct challenge to such a perspective, which appears to delegitimise AMHP decision-making at the point of referral for an MHA assessment. The rewording of s 13(1) MHA 1983 in 2007 may go some way to explain Quirk's (2007) oversight, for the words 'consider the patient's case' were only entered into statute at that time, however there is evidence from an earlier author that ASWs took the decision at the referral stage seriously pre-2007 (Thompson 1997; Thompson 2003).

Thompson (1997) included reflections on a practice example where he responded to a referral for an MHA assessment by visiting the service user and carrying out a unilateral assessment, deciding not to invoke a full MHA assessment. Key factors in this decision started with disruption to neighbours, communicated to the ASW by pressure from senior management to resolve the situation, leading to an assessment just by the ASW in which

the service user's physical appearance was troubling as was his description of psychotic symptoms. However, his ability to control himself to avoid high risk activity coupled with his agreement to engage in an alternative to admission were decisive in avoiding a full MHA assessment.

Thompson (2003) reflected on his experiences as an ASW, providing another case example where an ASW carried out some initial investigations into a request for an assessment, including meeting the person and concluding a full assessment was not merited. In this example, following concern from a member of the public the ASW visited the person who was street homeless and considered a relative comparison to other street homeless people concluding further assessment was not justified. A full assessment was arranged subsequently under direct instruction from senior managers, with Thompson (2003) highlighting such a situation was possible but "he could not be instructed to make an application" (p.42-43). Arguably the emphasis of s 13(1) MHA 1983 after the 2007 amendments make it impossible for an AMHP to be directed to carry out an assessment they believe to be unnecessary, but what Thompson's (2003) work highlights is that ASW/AMHPs in fact do make decisions at the point of referral for an MHA assessment, indeed supported by both Quirk (2007) and Glover-Thomas (2011) with the key difference being that Thompson acknowledged the legitimacy if not the legal basis of decisions at this point.

Thompson (2003) referred to another decision this time made very quickly at the point of the referral. An "immediate sense of critical pressure" (p.41) was evident from senior managers. Key factors otherwise were the service user's son feeling fearful and general concerns about the service user's mental health. High levels of perceived risk coupled with mental illness triggered a full assessment without further analysis.

Only four other authors mention the point of referral for an MHA assessment: Dwyer (2012) gave an example of receiving less than convincing referral information which she followed up by visiting the service user before concluding a full assessment was required under the MHA 1983. On meeting the service user Dwyer (2012) found him to be

> "violently disturbed and extremely threatening… [and] his terrible mental pain and anguish were clearly evident" (p.342).

These two factors again then, perceived high risk and mental illness, were used to determine the appropriateness of arranging an MHA assessment. The use of the word

terrible suggests Dwyer's (2012) emotional connection to the individual from meeting them and witnessing their mental distress.

Abbott (2018) also explicitly referred to the point of referral for an MHA assessment, however he described it as

> "the early stages of receiving the referral where the stage is set for the forthcoming assessment" (p.95).

The implication is that there is no decision to be made, and that the only outcome of a referral is an MHA assessment. Abbott is himself a practitioner researcher, but in his study all AMHP participants discussed an assessment which led to a decision to detain. It is therefore possible this offers some context to Abbott's (2018) correlation between referral and assessment.

Brammer (2020) considered decisions were made at the point of referral, but much like Quirk (2007) and Glover-Thomas (2011) he situated this decision outside the MHA 1983, albeit he found a significant consideration was whether the AMHP believed the criteria for detention would be met (Brammer 2020).

Rooke (2020) came the closest to exploring decision-making at the point of referral for an MHA assessment, specifically locating her recommendation to meet the person referred within s 13(1) MHA 1983, albeit she extended the legal basis to include s 115 MHA 1983 which is a power of entry and inspection due to welfare concerns provided the resident does not object. Rooke (2020) viewed such a meeting as a form of early intervention in situations of low risk.

Such scant insights into the decision at the point of referral for an MHA assessment highlight a significant gap in the literature that has justified further research to illuminate this experience. What we can legitimately discern from the literature to date is that while some acknowledge the decision, it is not necessarily viewed as a statutory one (Quirk 2007; Glover-Thomas 2011; Brammer 2020). Sometimes meeting the person referred helps inform the decision (Thompson 1997; Thompson 2003; Dwyer 2012; Rooke 2020). Where there is perceived high risk together with mental illness decisions may be made without further analysis (Thompson 2003). Self-control and a willingness to work with services led to a decision not to proceed with an assessment (Thompson 1997), while alternatives to admission may also be important (Quirk et al. 2003).

3.7 Conclusion

In this thesis I am concerned with AMHP decision-making at the point of referral for an MHA assessment however, there has been no research into this aspect of AMHP practice to date. As such in this literature review I have addressed the search question: what is known about the factors that influence AMHP detention decisions under the MHA 1983? I adopted a structured narrative literature review, identifying twenty-nine texts.

Through interpretive thematic analysis I identified risk, accountability, and morality as dominant themes. Risk was a prominent theme echoing the grounds for medical recommendations in s 2(2) and s 3(2) MHA 1983, but on closer inspection I found risk was infused with morality, more aligned with the broader grounds for the AMHP making an application in s 13(2) MHA 1983 "all the circumstances of the case". Wide variation was acknowledged; issues such as the social or medical orientation of the AMHP were relevant; and a knowledge of the person was significant. Risk cannot be viewed as an objective matter, rather it is subjective and interpretive, infused with morality. I have encapsulated morality as AMHPs merging their personal and professional domains, using themselves to understand service users when making detention decisions. Between morality and risk lies accountability, inextricably linked on both sides with authors identifying a fear of responsibility for adverse consequences.

Sub-themes of emotions, intuition, uncertainty, coercion, and alternatives are also present. These emerged from one or more of the dominant themes and whilst I have afforded them secondary status in this review, they nonetheless provide further insight into the review question.

Comparing and contrasting thirty years of literature regarding ASW/AMHP detention decisions what is clear to me from this structured narrative literature review is that they are not based solely on technical judgements. The literature is justified in evincing risk in detention decisions, but the prominence of risk overshadows accountability and belies the influence of morality. I have highlighted the pervasive nature of morality in AMHP detention decisions for the first time in this review, raising the question of whether services are structured in a way that supports AMHPs to achieve moral engagement in their role?

There is a simplicity to the themes identified in this review that belie their complexity and stand as testament to the intricacy of detention decisions, and by extension decisions at the point of referral for an MHA assessment. Issues of risk, accountability and morality

pervade detention decisions, with sub-themes merging to create a nuanced and complex environment within which decisions are made. No wonder then that AMHP detention decisions have attracted what has proven to be a significant body of literature: indeed six of the included texts were doctoral theses, while four other texts arose from or contributed to doctoral theses from other authors. That amounts to thirty years of doctoral study as a conservative estimate, not including the efforts of the nineteen other authors. When put into these terms it becomes even more striking that the decision at the point of referral for an MHA assessment has attracted no research. As a practitioner questions about this aspect of AMHP practice have arisen out of my practice, and the purpose of this thesis was to illuminate the point of referral for an MHA assessment to discover what can be learnt about AMHP decision-making at this point. Put in this way, a practice-based research methodology utilised for discovery made a natural home for such a study, and given in all the research included in this review only one study (Sheppard 1993) used such a methodology, I have sought to learn from practice in a way that promoted inclusion and ownership for its participants, for in this way the methodological barriers identified in this review have been broken down and new knowledge of value to practitioners has resulted. An appreciative stance facilitated this process further by promoting a level of engagement and motivation that might have been lost with problem-oriented methodologies.

Chapter 4 Methodology

As I began this research journey and I started to consider my perceptions on the nature of reality I quickly understood I was not seeking an absolute truth within a positivist paradigm. In relation to the experience of interest, I did not consider the necessity of assessment and detention existing as a definitive truth, rather I accepted the interpretive nature of reality where judgements are made and truths constructed. My research would therefore be qualitative.

Finding an appropriate methodology to research AMHP decision-making at the point of referral for an MHA assessment began with consideration of my insider status as an AMHP. I wanted to connect with other people's stories about an area of practice that interests me. When I explored ethnography and interpretative phenomenological analysis, I couldn't escape my concerns about positioning myself above my participants and the inherent criticism within this. As an insider researcher I was attracted to collaborative research methodologies where meaning could be constructed together with participants. I wanted to harness practice wisdom rather than position myself as an expert. Collaborative methodologies that promoted shared analysis of the data with participants seemed the perfect home for this insider research.

Action research didn't seem to offer a solution to inherent criticism because although collaborative its problem-oriented focus was a concern for me. There is no research into AMHP decision-making at the point of referral for an MHA assessment, and therefore this is an experience that is little understood. I did not believe a critical stance was warranted or helpful. The decision to be made is significant and complex, and in this sense it can be problematised, but there is no evidence to suggest that when AMHPs make decisions about whether to proceed with an assessment or not they do so in a way that is problematic.

The role of the AMHP is multi-faceted and at times contradictory, with little hope of balancing the expectations of all involved (Campbell 2010). In this sense there will always be scope to criticise AMHP practice, for all aims cannot be achieved. In traditional problem-oriented research it is all too easy for the problems of practice to rise to the surface as defining features, yet practitioners may feel defensive about their practice and therefore unreceptive to the messages the research seeks to convey. Adopting an appreciative stance would redress this issue and have the potential for greater relevance for practitioners. As such I wanted to find a strengths-based methodology.

Finally, while I accepted the benefits of research to further understand an experience, as a practitioner I wanted to find tangible practice implications as in action research, yet avoiding the problem focus.

Appreciative inquiry (AI) was developed by David Cooperrider as a "conceptual reconfiguration of action research" (Cooperrider and Srivastva 1987, p.130). AI distinguishes itself from action research in two key ways. Firstly, rather than being focussed on problems it adopts an appreciative stance, one that seeks to embrace what is currently working well. Reed (2007) observed this was based on Cooperrider's experience that

> "[a]sking positive questions seemed to be a very productive approach in both finding new information and exploring new methods" (p.22).

This shift from a focus on problems to a focus on what works was a key reason for my attraction to AI. My first aim was to illuminate decision-making at the point of referral for an MHA assessment, generating practice-based knowledge about this decision from the perspective of those who make it. AMHPs are required to make complex decisions independently at the point of a referral for an MHA assessment. The absence of research into this experience justifies redress. The idea of embracing what works in practice, what AMHPs do well spoke directly to the practitioner in me that seeks to build on strengths. In the same way I am drawn to an appreciative stance I believed those who participated in this research would value this approach and embrace the research process even more for it. These people were my colleagues and it was important to me that they did not come away from this experience feeling their practice had been criticised. Adopting an appreciative stance would allow participants to reflect on positive stories of practice and through those positive images resolve some of the paradoxical dilemmas that are likely with such a complex area of practice (Bushe 2001).

Pooler et al. (2014a) and Pooler et al. (2014b) researched joy in social work using AI. Starting from the recognition that research into social work has primarily focussed on problems, they sought to replicate the strengths focus of the profession by exploring joy in social work. This was one study published as two articles emphasising different aspects of joy in social work. Pooler et al. (2014b) reflected the positive focus of the methodology promoted positive feelings about the role, with these discussions generating joy themselves. I wanted this study to achieve similar aims; generating positive narratives about practice and encouraging a sense of pride in the role. As both a practitioner and a researcher I wanted this research to have a positive influence on practice. Generating

positivity about the AMHP role fit perfectly with this purpose, reinforced by Pooler et al. (2014b) who found their AI influenced a shift in the predominant narrative to the positive, with lasting benefits. The link to a strengths focus in social work is clear (SWE 2019), making AI appear to be a perfect fit for this study. The positive reflection on practice for positive practice outcomes resonates with a version of pragmatism that embraces hopefulness (Koopman 2006) and provides one underlying philosophical position that promotes tangible benefits for practice.

The second key way in which AI was developed to differ from action research is that AI addresses the separation between theory and practice typical of action research (Cooperrider and Srivastva 1987) and seeks to be different by building theory from practice. This is based on social constructionism discussed above, whereby “social reality, at any given point, is a product of broad social agreement” (Cooperrider and Srivastva 1987, p.134). This is an interpretive stance as opposed to a positivist one which views reality as objective truth. Reality as a social construct is impermanent and so change becomes possible. This represents the bridging of theory and practice, where the research

> “should lead to the generation of theoretical knowledge that can be used, applied, and thereby validated in action” (Cooperrider and Srivastva 1987, p.153).

AI then seeks to focus on what is positive and uses that to generate theory which itself can be applied to practice in the future to maximise achievements. Again, this resonated with the practitioner in me, valuing the AMHP role as it is and promoting ever better services from the people who perform the role.

AI is founded upon social constructionism. In this study of AMHP decision-making at the point of referral for an MHA assessment I sought to bring AMHPs together to talk about their experiences of practice and therefore socially construct a reality of the best of their practice. The social construction was one reality of many possibilities. As this AI moved through the dream, design and destiny phases AMHPs sought to promote their best for the future, establishing ways of working that supported this desire. To an extent this represented a reshaping of reality consistent with a challenge to institutionalised and habituated activity in social constructionist terms. The outcome was one reality of many possibilities. It was a reality valued by those involved in the AI, and in this sense, pragmatism offers another related interpretation of the AI process.

4.1 Principles

AI is based upon a set of five principles emanating from the original work of David Cooperrider's doctoral dissertation in 1986, but which have developed over time as the approach has been used. Whitney and Trosten-Bloom (2010) have cited eight principles which I will detail below integrating their relevance to this study.

4.1.1 <u>The constructionist principle</u>

One principle already mentioned is that AI is founded upon social constructionism, where

> "knowledge is a subjective reality—a social artifact resulting from communication among groups of people" (Whitney and Trosten-Bloom 2010, p.51).

In relation to AMHP decision-making, this perspective would assume there is not an objective truth in the positivist sense where the task of the AMHP is to successfully identify which people fall into which category; rather the defining characteristics and circumstances that constitute the need for an MHA assessment will be subjective but shared among AMHPs through language. Whitney and Trosten-Bloom (2010) went on to reinforce this shared dimension:

> "Knowledge—that which is considered good, true, and meaningful—is a broad social agreement created among people through communication" (p.53).

Collectively then AMHPs may create knowledge about who requires an MHA assessment and who does not through communicating with each other and establishing the parameters of this constructed reality. From my practice experience I believe there is much merit in adopting this perspective on the nature of reality. Despite the independence of decision-making within the role my experience has shown me that AMHPs will talk through their practice dilemmas with their colleagues if they are not working in isolation and in so doing may begin to construct a reality through language with their colleagues. This may be viewed as a form of reflection in action, where we may "reshape what we are doing while we are doing it" (Schön 1987, p.26). Schön (1987) linked constructionism with professional reflective practice in a similar way:

> "In the constructionist view, our perceptions, appreciations, and beliefs are rooted in worlds of our own making that we come to accept as reality. Communities of practitioners are continually engaged in what Nelson Goodman (1978) calls 'worldmaking'" (p.36).

Kinsella (2006) later interpreted Schön's perspective as constructivist rather than constructionist, whereby: "Individual practitioners are seen as constructing viable worlds of

their own making" (p.285). The central distinction is therefore whether reality is constructed by individuals or whether it is constructed among groups through language. Relating this to AMHP decision-making it is perhaps helpful to review the findings from my literature review which highlighted the subjectivity inherent in AMHP decision-making regarding compulsory admission under the MHA 1983. This conclusion would lean toward the constructivist perspective, however the margin of similarity within and between studies enabling the identification of themes supports an element of enculturation. For a constructivist approach to dominate the variation between individual AMHPs might be marked and even contradictory but, adopting a social constructionist perspective would support a level of normalisation of decision-making between AMHPs. Glover-Thomas (2011) found support for the latter from one participant who espoused

> "the notion that practitioners' professional imperatives would ensure that the concept of risk generates consistency in the aggregate" (p.591).

My inclination is similarly to the social constructionist perspective and therefore the acceptance of shared meanings. This is consistent with Quirk et al. (2003) who identified geographical variation in AMHP detention decisions based on operational norms. I do not however believe there is any contradiction when faced with the element of subjectivity because shared meanings do not necessarily equate to shared decisions. I would adopt a perspective that shared meanings within the context of AMHP decision-making will provide certain parameters, practice norms and accepted wisdoms. However, the infusion of morality identified in my literature review will also have an influence on AMHP's decision-making bringing forth the subjective dimension.

The construction of reality in both constructivist and social constructionist terms promotes language as a means of creating reality, and it is this central tenet that after Schön (1987) allows the reflective practitioner to make sense of complex social situations. AI values the role of language in creating reality and in this sense mirrors this premise upon which reflective practice is built. For this reason, AI and the constructionist principle complement the practice-based approach desired for this study of AMHP decision-making at the point of a referral for an MHA assessment.

4.1.2 The simultaneity principle

The second principle of AI is simultaneity, where "change occurs the moment we ask a question" (Whitney and Trosten-Bloom 2010, p.55). This principle again has links to reflective practice, this time experiential learning and reflection on action (Kolb 1984),

where reflection on concrete experiences can enhance learning from those experiences. This is foundational in practice learning and as such is often utilised in professional supervision. Indeed, the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 stipulate AMHPs should

> "exercise the appropriate use of independence, authority and autonomy and use it to inform their future practice as an AMHP, together with consultation and supervision" (Schedule two, 5(f)).

Implicit within this competence is the constructionist principle of shared meanings and language through consultation, and the simultaneity principle through promoting consultation and supervision to help inform future practice. AMHPs then are encouraged through the regulations to talk about their practice and learn from it, the basic constituents of reflective practice. On AI Reed (2007) supported the connection between reflection and simultaneity:

> "An inquiry is an intervention in the way it stimulates reflection and thought that lead to different ways of thinking and doing" (p.26).

Crucial to AI is the notion that focussing on the positive "evokes hopes and dreams for the future and generates life-giving possibilities" (Whitney and Trosten-Bloom 2010, p.57). This aspect of AI inspired me; I connected with the notion of learning from what has gone well in practice rather than from what has gone wrong; the idea that once we start reflecting and talking about what has gone well, this will contribute to a strive to replicate these positive aspects of practice, normalising them for the future (Elliott 1999).

4.1.3 The poetic principle

The poetic principle relates to the choice of what to study and how this becomes fateful and creates what we discover (Whitney and Trosten-Bloom 2010). In discussing the point of a referral for an MHA assessment, a focus is on when this has gone well would uncover positive elements, whereas a focus on circumstances that have not gone well would uncover negative elements. As a practising AMHP there is a lot I feel proud of about the role and the way it is performed. These are the aspects that provide my continued motivation to remain in practice; they provide meaning and purpose. A movement towards enhancing the best of practice both values practice and seeks achieve the best every time. As a practitioner researcher, valuing the practice of those participating in the research would help to sustain my ongoing practitioner status, something that would be far more challenging if my stance were critical toward practice.

4.1.4 The anticipatory principle

The anticipatory principle relates to how the future images impact on current practice. These images exist in dialogue and if positive can stretch the imagination “like a flower growing toward the sunlight” (Whitney and Trosten-Bloom 2010, p.62). Reducing coercion has been set as a goal for MHA reform (DHSC 2018), but a focus on this negative image would breed more barriers than positive solutions. If translated into a positive future image of working cooperatively with mental health service users, then it is easier to appreciate the benefits of focussing on positive ways to strive toward this rather than the barriers that prevent it. Indeed, an AMHP seeking to avoid coercion will before long become conflicted, but an AMHP seeking to work cooperatively with mental health service users will strive toward this in every interaction and will experience varied levels of success.

4.1.5 The positive principle

The positive principle is based on the belief that “positive questions lead to positive change” (Whitney and Trosten-Bloom 2010, p.63), but also that people engage more deeply and are more interested in positive ideas (Reed 2007). I can relate to this in my practice as an AMHP, where conversations with my colleagues about problems tend to become circular and unproductive, whereas conversations about positive practice breed enthusiasm and inspiration.

4.1.6 The wholeness principle

The wholeness principle provides an interesting embrace to subjectivity, for its focus is on embracing differing views rather than seeking commonality; the whole story incorporates differences and is a synthesis of multiple stories (Whitney and Trosten-Bloom 2010). There are parallels to AMHP practice with this principle because the AMHP is tasked to consider “all the circumstances of the case” (s 13(2) MHA 1983). In any given situation where an MHA assessment is being considered there will be a range of stories to uncover, from that of the person subject to the consideration to any relevant family, carers and professionals involved. Gaining an understanding of the situation in order to consider all the circumstances cannot be achieved by listening to just one story. Such similarities between practice and this methodology contribute to the cohesiveness of the approach to this study.

4.1.7 The enactment principle

The enactment principle is about "living one's dreams today" (Whitney and Trosten-Bloom 2010, p.70). Overlapping with the anticipatory principle, enactment supports that positive ideas will impact practice immediately. If for example cooperation is desired, then enactment is about cooperating in our practice today. With the principle of empowerment and involvement (DoH 2015, chapter 1.1) this enactment of a desired future is already embedded in AMHP practice. These guiding principles provide some desired futures that are enacted to varying degrees of possibility now. AMHP practice then embodies enactment already, providing a platform from which to build future desired changes through AI.

4.1.8 The free choice principle

The free choice principle seeks to breed enthusiasm through free choice about participation. This is perhaps a somewhat odd inclusion principle for a research methodology, where research ethics already address this matter, however AI was developed as a tool for organisational development and in that context the principle makes greater sense.

There is much overlap between these principles but together they represent a coherent and consistent approach to research that is founded on positivity, co-operation and communication. Broadly speaking these principles replicate what Hammond (1996) cited in Reed (2007) termed assumptions:

1. "In every society, organisation, or group, something works.
2. What we focus on becomes our reality.
3. Reality is created in the moment, and there are multiple realities.
4. The act of asking questions of an organisation or group influences the group in some way.
5. People have more confidence and comfort to a journey to the future (the unknown) when they carry forward parts of the past (the known).
6. If we carry parts of the past forward, they should be what is best about the past.
7. It is important to value differences.
8. The language we use creates our reality" (p.27-28).

4.2 The process of an appreciative inquiry

The principles of AI provide an overarching philosophy and value position to the methodology, the very aspects I found hard to conceptualise at the beginning of this

journey. Unlike other methodologies there is not a prescriptive approach to AI as eloquently described by Whitney and Trosten-Bloom (2010):

> "It is not a singular methodology because it is not based on one firmly established way of proceeding. Like great jazz improvisation—a metaphor proposed by consultant Frank Barrett—each Appreciative Inquiry is a new creation, an experiment that brings out the best of human organizing. It begins with a clear purpose. But from there, who knows precisely what will happen?" (p.13).

Such variation in how AI is implemented initially appeared quite confusing, as studies using the approach seemed to share little in terms of their methods. It is for this reason I began my description of AI with the principles, for conceptualised in this way coherence using the approach becomes more obvious. The methods adopted in an AI represent the specific techniques, but the essence of the AI is in the broader aspects of collaboration and strengths (MacCoy 2014). As above however, all appreciative inquiries begin with a clear purpose translated into an affirmative topic choice.

4.2.1 Affirmative topic choice

Rather than starting with a defined research question AI starts with a collaborative process of affirmative topic choice. An affirmative topic choice sets a "strategic course for the future" (Cooperrider and Whitney 2005, p.17), which links directly to the poetic principle described above. Unlike traditional research approaches, appreciative inquiries are not meticulously planned, rather "people share and develop ideas together" (Reed 2007, p.96). The affirmative topic choice is the first example of this in an AI, to ensure that the topics chosen "focus on what members of an organization want to see grow and flourish" (Whitney and Trosten-Bloom 2010, p.132). The focus on the organisation is common within AI literature due to its concentration on organisational development. Its application as a research methodology offers a focus beyond the organisation however, with Reed (2007) having highlighted how the focus may be on "particular practice" (p.92) as is the case in this study. Moving beyond the organisation, this AI sought to understand AMHP practice, more specifically decision-making by AMHPs, and more specifically again decision-making at the point of referral for an MHA assessment. This is what I have referred to as the experience of interest, but it is not an affirmative topic because it does not set a direction of travel or a desired future. When it comes to an affirmative topic that seeks to promote what members wish to see flourish, the frame of reference becomes the practice of the participants involved in the study rather than the strategic direction of an organisation. Miles et al. (2018) called this the definition stage, and in their study of distance learning experiences

(the experience) they held collective workshops for participants to define the focus of the study. This represents a level of collaboration between researcher and participant absent from traditional research methods. The scene is set early in the process that the agenda is not predefined; power within the research process is somewhat more evenly distributed in the same way that AMHPs may seek to hear the voice of service users throughout the assessment process. This parallel with anti-oppressive practice further supported the benefits of AI in the exploration of AMHP decision-making at the point of referral for an MHA assessment.

Whitney and Trosten-Bloom (2010) define four characteristics to the choice of an affirmative topic: They should be positive, desirable, they should stimulate learning, and they should stimulate conversation about desired futures. They further suggest between three and five affirmative topics should be developed to guide the AI.

Appreciative inquiries do not follow a linear process, where the research journey moves from a starting position to a conclusion, rather the process is cyclical mirroring the earlier referenced reflective practice models of Kolb (1984) and Schön (1987). In AI changes become “integrated and sustained with the reflection that AI stimulates” (Reed 2007, p.32). This offers a powerful benefit of the approach when applied to professional practice, where the research endeavour becomes more than just a snapshot of practice but promotes positive changes in practice over time toward the desired futures envisaged by the participants.

The main cyclical process developed to shape an AI is the 4-D cycle (Whitney and Trosten-Bloom 2010) offering a guide to the process of an AI, though Mullen et al. (2018) highlighted that “modified approaches may only focus on one of the 4Ds” (p.107). Viewed as guidelines this cycle offers a tangible insight into what might constitute an AI without the prerequisite that it must be rigidly followed. I will explain the 4-D cycle with reflections on what this process had to offer this study.

4.2.2 The 4-D cycle

4.2.2.1 Discovery

4.2.2.1.1 Appreciative interviews

The discovery phase centres around identifying the “best of what has been and what is” (Cooperrider and Whitney 2005, p.16) and fundamental to achieving this is the appreciative

interview. Reed (2007) highlighted that this can be difficult as "the negative often seems more vivid and important" (p.33). MacCoy (2014) gave an example of a participant walking out angered in the belief the approach would not address problems, and so he highlighted the importance of assuring participants that problems will not be ignored, but the desired future will be the focus.

In the discovery phase the affirmative topics are transformed into positive questions designed to elicit a narrative of best practice from participants (Whitney and Trosten-Bloom 2010). In this sense the discovery phase is the storytelling phase of AI. This narrative focus embraces the constructionist principle and again highlights parallels with reflective practice; as a practising AMHP my experience is that the telling of the MHA assessment story is frequently adopted in both supervision and peer reflections as a tool for making sense of the process and promoting learning. AMHP participants felt comfortable with this process of discovery as it was consistent with their everyday experience.

Generally, those who identify the affirmative topics transform them into positive questions (Whitney and Trosten-Bloom 2010), maintaining the collaborative nature of the approach. The development of these questions is seen as something creative and provocative, possibly using metaphors or miracle questions (Whitney and Trosten-Bloom 2010). Liebling et al. (1999) described the appreciative protocol (questions) as "a list of opening gambits" (p.79). Appreciative interviews encourage narrative and storytelling rather than being too prescriptive. Liebling et al. (1999) further defined their interviews as "lightly structured talk" (p.76) which conceptualises the interview well; the idea is to use positive generative questions to stimulate reflection on best practice. Whitney and Trosten-Bloom (2010) suggested questions that look back on positive experiences (such as *tell me about a time when you did this at your best?*); questions that look inward to explore the impact of positive experiences (*how did you feel about that experience?)*; and future-oriented questions that consider an ideal future (*imagine a future where everything is as you hoped: what does this look like?)*. The approach seemed liberating, providing participants the opportunity to explore what was important to them through the interview. Indeed, The staff at Mountbatten Hospital et al. (2005) found the interviews ""cathartic" in psychotherapeutic terms" (p.49). Liebling et al. (2001) reflected "AI seems to take better care of informants and participants" (p.164). In my position as a practitioner carrying out research with my colleagues this was a distinct benefit, helping to promote reciprocity.

Unlike traditional research approaches, appreciative interviews may be carried out between participants rather than by the researcher, allowing the participants to connect, share stories and “ignite this spirit of inquiry” (Cooperrider and Whitney 2005, p.26). These stories are then shared and a process of meaning making by participants leads to the identification of the positive core, or “a unique set of strengths, resources, skills, and assets” (Whitney and Trosten-Bloom 2010, p.164). The participatory nature of these processes shatters the traditional divide between research and practice, though Carter (2006) highlighted that, in research rather than organisational development, the collaborative nature of AI is often diluted with the researcher carrying out the appreciative interviews. Traditional research methods place the researcher in a position where they can “maintain control over a study” (Reed 2007, p.111), and it is easy to understand why some researchers might find it difficult to let go of this control. Indeed, this study of AMHP decision-making at the point of referral for an MHA assessment represented a significant life focus for me, with a substantial amount of time spent considering methodology and method. There was a contradiction in spending so much time planning a study to then release control at the critical point of data collection. Yet to do so spoke directly to the core of AI: Appreciation is about “recognition, valuing, and gratitude” (Whitney and Trosten-Bloom 2010, p.2). The participants taking part in this study had a wealth of experience to draw from to illuminate AMHP decision-making at the point of referral for an MHA assessment, and exploring this together enabled participants to share these experiences and value their differences, creating new shared stories for change (van der Vaart 2017); “inquiry requires sincere curiosity and openness to new possibilities” (Whitney and Trosten-Bloom 2010, p.3), releasing control seemed an apt way to achieve this. Rather than a contradiction then collaboration *is* AI and diluting this undermines internal consistency. Embracing collaboration requires a shift in focus from viewing research as a process of *uncovering* data to one of *creating* and generating data (Reed 2007). The discovery phase then became a process not just of uncovering the best of current practice, but a creative process of interpreting what was the best of now to carry forward to the future.

4.2.2.1.2 Data analysis

Within the discovery phase after appreciative interviews comes a process of meaning making. Whitney and Trosten-Bloom (2010) suggested a narrative analysis to “extract themes” (p.163) but also “seek out the lone, inspired voices” (p.162). Crucially this meaning making process is achieved with participants, another example of collaboration and

deviance from traditional research methods. This for me represents a key element of carrying out research that practitioners' value; meaning is not imposed by the researcher; the researcher is not positioned as the expert, rather the participants are the experts in their experience. There are clear parallels here with the recovery model in mental health whereby service users will define their personal recovery rather than clinicians (Rethink Mental Illness 2016). Again, it is necessary to remember the process of an AI is not prescriptive, and so for example Scerri et al. (2015) and Rawles (2016) analysed their own data; Bellinger and Elliott (2011) at the insistence of the ethical review board utilised a tandem process of a research assistant analysing the data while separately the research group also analysed it, comparing the results at the end; Salyers et al. (2015) used a team based iterative approach that included two staff members at the community mental health centre they studied, their paper remaining unclear as to whether these two staff members also participated in the study; and Reed et al. (2002) enabled participants to analyse the data. Validity may be a concern when participants analyse the data, but strategies can be adopted to enhance transparency (Reed 2007).

4.2.2.1.3 Mapping the positive core

The culmination of the discovery phase is the illustration or mapping of the positive core, or "the essence of the organisation at its best" (Whitney and Trosten-Bloom 2010, p.164). This is represented as a "chart, picture, or illustration" (Whitney and Trosten-Bloom 2010, p.165) and is continually referred to throughout later phases of the AI. Identifying the essence of AMHP decision-making at the referral stage of the MHA assessment process was to become illuminating, for this is a decision that exists both in law and practice yet is overlooked by those writing about AMHP practice and those tasked with providing guidance to AMHPs such as the DHSC. How was an aspiring or newly qualified AMHP to conceptualise this decision? Mapping the positive core of this decision would charter new territory in understanding what happens now.

4.2.2.2 Dream

> "Appreciative inquiry dreaming lifts up the best of what has been and invites people to imagine it even better" (Whitney and Trosten-Bloom 2010, p.177).

While discovery illuminates the best of now, dreaming is the first stage of considering change to improve what is happening now. Reed (2007) defined this phase as "thinking creatively and thinking big" (p.33), so the focus is not on small changes but broader more

idealistic ones, “questions of purpose and calling” (Whitney and Trosten-Bloom 2010, p.180).

Despite thinking big, dreaming is based on the best of now, so the dreams are “grounded in reality” (Elliott 1999, p.2). As such they can be realistically built rather than being a wish list of unachievable aims. Based on the anticipatory principle, dreaming begins in the appreciative interviews where the best of now is projected toward the future. Liebling et al. (2001) reflected on their 1999 published study that energy was generated toward best practice through appreciative interviews. Another author reflected this notion in her exploration of the criticism of practitioner research, in which she summarised that it

> “sometimes moves far too quickly from exploring what *is*, to advocating what *ought* to be the case” (White 2011, p.6).

Yet in AI this is precisely what is desired; the purpose of the discovery phase is to set in motion a shift toward enhancing the best of now, to dream of what ought to be. Dreaming is then where AI starts to deviate from research which seeks solely to understand an experience, moving toward enhancing the best and growing in the direction of improved practice. This remains distinct from problem-oriented research, maintaining a focus on enhancing positives rather than fixing negatives. Using AI as a method of inquiry Liebling et al. (2001) reflected a sense of abandoning the participants and so moving into the latter phases of AI in their subsequent study represented the way in which the research was able to repay participants for their efforts. This notion of reciprocity was an important consideration for my study when considering my initial rationale: I wanted to understand practice but also produce something of use to practitioners; as a practitioner myself my principal focus in its most simplistic form is to *do a good job*, whatever that might look like. Discovering the best of now would help toward this aim, naturally engaging participants through the anticipatory principle toward enhancing the best of now, but in its developmental sense dreaming started a process of more tangible benefit to practitioners.

AI dreaming is usually carried out in groups and often assumes a creative form. The process begins with participants identifying a focal question which may be based on the appreciative interview questions or may be tailored by the group (Whitney and Trosten-Bloom 2010). Questions from the appreciative interview will have sought the best of now but also projected forward and so it is those questions that may form the starting point for dreaming together. Dreaming is achieved through conversation within the group setting where “themes and patterns begin to emerge organically” (Whitney and Trosten-Bloom

2010, p.187). Creativity may be introduced by enacting the dreams and seeking common themes with the aim of creating a vision statement to form the basis of the design phase (Whitney and Trosten-Bloom 2010).

4.2.2.3 Design

The design phase follows from and merges with dreaming much in the same way as discovery overlaps with dreaming. Design is about "craft[ing] plans for the future" (Reed 2007, p.33), based on the desired future from dreaming, and encapsulated in narratives or statements that imply change will occur, termed provocative propositions among other things (Whitney and Trosten-Bloom 2010). Provocative propositions "realistically sum up 'what could be'" (Carter 2006, p.56). These provocative propositions form the basis of change in the destiny phase. Change in the context of AI relates to enhancing the best, building, growing, developing; positive notions of forward momentum rather than fixing problems.

4.2.2.4 Destiny

Destiny is the phase in which "the future will be made real" (Whitney and Trosten-Bloom 2010, p.220). It is the implementation of change to achieve the provocative propositions, often involving innovation teams to make this happen (Whitney and Trosten-Bloom 2010).

The progression of AI from discovery to altering practice in some way through dream, design, and destiny offers tangible outcomes to the process; practice will shift in the way the group determine it should in a truly socially constructed but also a pragmatic sense. The best of now is agreed and enhanced, identifying the best for the future and creating this as a new reality.

4.2.3 Modified approaches

Some studies focussed on understanding do not move beyond the discovery phase, such as Salyers et al. (2015) who sought to understand what community mental health staff thought they were like when they were at their best. They identified a key theme of their best being when they "perceive themselves as competent and caring" (Salyers et al. 2015, p.295), with an implication being the importance of staff hearing about successes (Salyers et al. 2015). Scerri et al. (2015) sought to understand what works well in dementia care in hospital, leading to "understanding the changes required to enhance the quality of dementia care" (p.1924). The goals of these studies in many ways mirrored the objectives

of this study, with the focus on generating new knowledge about a largely neglected area of AMHP practice within the current literature.

My choice of AI was primarily motivated by its positive focus therefore avoiding any implicit criticism of current practice; and its collaborative nature which both values the experience of the participants and helps to bridge the theory to practice divide. The outcome of this study would hold greater meaning for practitioners with this approach, illuminating the best of current practice and inspiring reaching this goal every time. As an exercise in reflective practice identifying the best encourages achieving the best every time, and in this sense, dreaming occurs naturally based on the anticipatory principle. Indeed, following appreciative interviews Liebling et al. (1999) found "consciousness was beginning to shift in a deep and significant way" (p.92). Isolating discovery and dreaming then may be an unrealistic goal.

It is perhaps useful to reiterate that the 4-D cycle described above is better viewed as a guide rather than a prescriptive method for achieving an AI;

> "it is the collaborative inquiry into the "life-giving forces" or strengths of a system combined with imagining a desired future and co-creating solutions to get there that is closest to the essence of AI" (MacCoy 2014, p.112).

This study sought to understand an experience; but as a practitioner I didn't want to stop there. I wanted this study to be experienced as a tool for practice development. Excellent practice can always be enhanced, and it is difficult to argue against the benefit of striving ever further to achieve more, better. There was nothing implicit in this about practice now; I was not suggesting practice particularly needed improving, rather I acknowledged that the best of now could be used to construct an even better future.

4.3 Positivity and criticality

AI has been criticised for a bias toward the positive, but many argue that traditional research focussing on problems can be similarly criticised for a bias toward the negative (Liebling et al. 1999; Carter 2006; Bellinger and Elliott 2011). Reed (2007) conceptualised the positive bias of AI as the focus of the research, much like all research must define a focus. In this way Reed (2007) argued AI studies cannot be claimed to be definitive, indeed no study "can claim to do everything" (p.76). In a study to understand relationships between prison officers and prisoners, Liebling et al. (1999) contended that the research in this field is predominantly focussed on the negative and so the rationale for an appreciative approach was to counter this and be "deliberately *partial*" (p.76). The choice of

methodology then became the choice between which partial insight to adopt, and a focus on the positive attracted me firstly because of the positive principle that "positive questions lead to positive change" (Whitney and Trosten-Bloom 2010, p.63). A positive focus aligns well with a pragmatist position; "change is promoted through building on the positive rather than concentrating on problems" (Reed 2007, p.75), thus outcomes are more likely to have a practical application. The second reason I was attracted to a positive focus, also relating to the positive principle, was that people engage better when the stance is positive (Reed 2007). The role of the AMHP is multi-faceted and at times contradictory, with competing expectations (Campbell 2010). In this sense there will always be scope to criticise AMHP practice. In traditional problem-oriented research it is all too easy for the problems of practice to rise to the surface as defining features, yet practitioners may feel defensive about their practice, limiting their contribution. Adopting an appreciative stance redressed this issue and promoted positive engagement in the research.

An appreciative stance toward practice and the desire to carry out research of meaning to practice brought the possibility of collaboration with participants closer. As Carter (2006) reflected from experience, AI "genuinely does build collaboration and partnership" (p.52). This represented a compelling attraction for me as a practitioner researcher where I would continue to practise alongside my participants.

The positive bias of AI can be misinterpreted as disallowing negative stories; however, Bellinger and Elliott (2011) highlighted that negative experiences are incorporated into AI, and that

> "interrogating those experiences within a positive context means that creative and innovative alternatives can be explored" (p.713).

There are parallels here with reflective practice, where challenges can be reframed as learning opportunities with positive outcomes.

Reed (2007) highlighted how the positive focus of AI can be paradoxical; where criticism is enculturated, adopting a positive stance critically challenges normal representations.

The positive focus of AI encouraged a reframing of problems toward that which is desired (MacCoy 2014). This is paradoxically critical, with Fitzgerald et al. (2010) using a shadow metaphor to highlight how the positive focus in AI simultaneously draws attention to that which the positive excludes. They proposed the wholeness principle of AI is enhanced by

learning from painful or difficult experiences (Fitzgerald et al. 2010). This was evident in this AI, where the recognition of the best of practice generated enthusiasm for creating the conditions that would promote achieving this more of the time. There was no value in dwelling on when this might not be the case, rather the focus was on how to make it possible.

Of central importance to criticality in AI is the generative nature of conversation.

> "As we talk to each other, we are constructing the world we see and think about, and as we change how we talk we are changing that world" (Bushe 2001, p.118).

In its generative capacity Bushe (2010) highlighted how AI can turn toward problems and seek ways of aligning the change process to address them through positive dreams rather than dwelling on the negativity.

As I moved into the design of my study, the way in which I created this unique AI, I conclude the methodology chapter not just with the acceptance of positivity, but a celebration of it; this study seeks to promote the best of practice now, for it is the best of practice that we aspire to replicate.

Chapter 5 Methods

This study relates to AMHP decision-making at the point of referral for an MHA assessment. There is no statutory guidance available to the AMHP for this decision, and there has been no prior research to guide practice. Each AMHP approaches this decision in their own way, likely informed by the way in which they see other AMHPs approach the decision and expanded upon through their own experience. The decision lacks attention in the literature and so anything that is known about it is anecdotal and experiential. I have long been fascinated with this decision and my intention in this study was to shed light on it. As such this was a study which sought to generate knowledge for understanding current practice.

There are many reasons why I chose to adopt AI as a methodology, but the principle reasons related to its participatory and positive nature. As a practitioner I was drawn to participatory approaches because I believe a lot can be learnt from practice; my desire was to embrace the experience of my participants and involve them in the whole research process rather than try to position myself as an expert ready to advise practitioners how to approach their practice. As an AMHP facing this decision regularly I also appreciate how complex it is; I value the role of the AMHP and believe an appreciative understanding of this difficult decision is more constructive than a critical one. Liebling et al. (1999) acknowledged in their study of prison officers about how previous studies had taken a critical stance on the role, and the AMHP role can similarly be viewed negatively due to its conflicting purposes (Campbell 2010). Adopting a positive stance would uncover aspects of the role that would not be identified in a study adopting a critical stance. In the design of this study I sought to maintain consistency and authenticity by ensuring the study was both participatory and positive. I make this point explicitly at this juncture as guided by Holloway and Todres (2003) in order to promote transparency and authenticity.

5.1 Participant selection

This study related to an independent decision by a specific group of people fulfilling a specific statutory role. The decision impacts a range of people and agencies, and another study may have sought to bring stakeholders from across the system to contribute to an inquiry, but this was not my intention. I was interested in how AMHPs make decisions at the point of referral for an MHA assessment, not how other people view those decisions; the AMHP is tasked without statutory guidance to “consider the patient’s case” (s 13(1)

MHA 1983) and the focus of this study was how the AMHP achieves this; what influences their decision; using AI terminology, how they define the 'positive core' of this decision (Whitney and Trosten-Bloom 2010). I was interested in the experience of the participant AMHPs rather than trying to seek some universal cross-stakeholder agreement about best practice.

Local authorities perform many functions, and the purpose of this study was not organisational change in the broad sense. As such I did not seek to bring a range of people from the organisation together; local authorities are required by statute to provide AMHPs to make decisions about whether to proceed with an assessment or not (s 13(1) MHA 1983), but AMHPs do not act at the behest of the local authority (s 13(1A) MHA 1983). The focus of this study was on illuminating professional practice; therefore, the participants could only be those performing the AMHP role.

Appreciative inquiries address an organisational change agenda, using the 4-D cycle to design and implement positive change (Whitney and Trosten-Bloom 2010). On a smaller scale and referring to only one part of the organisation, this AI was no different; I sought to identify the best of AMHP decision-making now and work collaboratively to enhance this for an even better future. There are 148 local authorities in England and Wales and 3800 practising AMHPs (Skills for Care 2022). It would have been unrealistic to seek commitment from so many organisations toward a change agenda, and as such this study did not seek to do this. The focus on change brought the scope of the study back to the organisational level, where a shift in policy and practice was achievable. As a result, this study sought to include practising AMHPs from one local authority.

Inclusivity is key in appreciative inquiries for organisational development, yet as a research methodology sampling is important (Reed 2007). For this study all participants must have had experience of the AMHP role, or more specifically they must have been current practising AMHPs at the time of the study in order to reflect on their current experiences of AMHP decision-making at the point of referral for an MHA assessment. Additionally, all participants must have been employed by one local authority so that a change agenda could be realistically implemented.

I work in a local authority that employed approximately twenty-four AMHPs not including bank staff. Those AMHPs contributed to two daytime AMHP rotas and one out of hours rota and comprised people who only fulfilled the AMHP role, people who regularly

performed the AMHP role but had other roles in addition to it, and people who principally held another role but maintained a minimal AMHP role. The first two categories of staff would be employed substantively as AMHPs. This study only sought to include core staff with substantive AMHP posts in the local authority where the role formed part of their day to day responsibilities. For this reason, agency staff, bank staff, and individuals who only performed the AMHP role occasionally were excluded. This left sixteen AMHPs eligible to participate in the study.

Group characteristic sampling strategy is advocated by Patton (2015) as one of many ways he identifies to select “information-rich cases” (p.264). One such strategy is a complete target population, including “everyone in a group of interest” (Patton 2015, p.285). In this study such a strategy would have involved including all sixteen AMHPs employed by the local authority. However, adhering to both research ethics and the AI principle of free choice participants must have the option to decline participating. In this way the sampling strategy of complete target population of sixteen became the initial intention, recognising that the final sample would be self-selecting from the target population (Hughes 2011).

Befitting AI, the research method was group-based rather than individual interviews. The term ‘workshop’ was in common use in my work setting as a space for reflective learning. Workshops “are conducted by people with experience within the domain” (Ørngreen and Levinsen 2017, p.72). Like AI this method is founded upon social constructionism because the conversation is of primary importance; reality is constructed between the participants and researcher alike:

> “The workshop co-constructs a place for collaborative negotiation of meaning – not only between participants, but also between facilitators (the researchers) and participants” (Ørngreen and Levinsen 2017, p.78).

The notion of co-creation was an important consideration for this study, for as a practising AMHP my experience would influence my interaction with the participants attending the workshops; my subjective experience would add to the subjective experiences of participants to shape the findings of the study. This was a critical issue when it came to rigour, but while I did not seek to deny the validity of my own experience, I did need to seek explicit ways of understanding how my involvement as researcher impacted on the study. I will address this consideration further when I explore other aspects of rigour in relation to the study.

As a practising AMHP in a local authority I had direct access to potential participants within my work setting. These were participants familiar to me, and as Mercer (2007) wrote "[i]t is generally presumed that access is more easily granted to the insider researcher" (p.6).

Ørngreen and Levinsen (2017) suggested the "participant group is kept small to allow everyone personal attention and the chance to be heard" (p.72). Kuzel (1999) suggested "five to eight data sources or sampling units will often suffice for a homogeneous sample" (p.42). A sample of practising AMHPs within one local authority was homogenous because they were people with "similar backgrounds and experiences" (Patton 2015, p.284). Of focus groups Gaižauskaitė (2012) commented "few participants are not enough for the evolvement of discussion; too many are difficult to manage" (p.24). Gaižauskaitė (2012) went on to suggest between six and twelve participants is ideal.

AI promotes broad inclusion, "engaging all members of an organization or community" (Cooperrider and Whitney 2005, p.15). With a total population of sixteen this was a manageable sample size for this study. I therefore adopted a homogenous and complete target population sampling strategy while embracing the free choice principle, participants self-selecting from the whole population.

All substantive AMHPs in the local authority I work in were invited to participate in the study via an email providing participant information (see appendix four). Participants were made aware that participation was optional, and they could withdraw at any time.

5.2 Being an insider

5.2.1 Working with colleagues

Working with participants who were also my colleagues had some obvious benefits and drawbacks, particularly in relation to my position in the organisation. As colleagues we had developed trusting and respectful relationships, which should have proven helpful in terms of recruiting participants and engaging them in the research process. However, as AMHP Lead I also supervised many of my potential participants, and so I was in a relative position of power which could have inhibited their willingness to be completely honest (The staff of Mountbatten Ward et al. 2005). In fact, participants may have felt coerced to participate, and their honesty may have been constrained by my continuance in the organisation (Rossman 1984). Malone (2003) went further to highlight this will be the case no matter how many assurances I offered participants therefore I had to acknowledge this vulnerability. Malone (2003) went on to highlight the unintended negative consequences

for participants and the researcher alike, such as what we would find out about ourselves and our colleagues: the myth of anonymity; the potential trauma for participants of reading my interpretations; the impact on relationships beyond the study. These were all significant concerns that could not be avoided. Malone (2003) described her earlier ignorance as naïveté, and while as a novice researcher I shared this position I remained hopeful that these issues could either be made explicit or they could be mitigated to reduce potential harm. I hoped adopting a strengths-based approach rather than one focussed on deficits would help to create a positive and uninhibited atmosphere, nurturing interpersonal relationships rather than harming them. That said it was important to be explicit about respecting the views of others at the start of each workshop.

Appreciative interviews can be carried out by the researcher such as with Carter (2006), but it is more collaborative when these interviews are conducted between participants themselves as with Reed et al. (2002). Adopting the latter distanced me from the data collection a little and in this way may have lessened the impact of my relative position within the organisation. However, to distance myself from the appreciative interviews was not the same as removing any influence I might have had over the data generated. Mercer (2007) highlighted the way in which researcher opinions are more likely to be known by participants in insider research, and therefore participant accounts may become distorted. Despite doing so herself, she advocated that

> "it is usually better for insider researchers not to publicise their own opinions about their research topic" (Mercer 2007, p.13).

This was unachievable in this study given I worked alongside my participants and therefore my opinions were open for all to see. However, I needed to ensure the wholeness principle of AI was promoted in the workshops, being explicit that while many participants would know some of my views their views were equally valuable and would be incorporated appreciatively. Additionally, Darra (2008) referred to the potential for participants to want to avoid talking about practice that casts them in a negative light, or alternatively that seeks to promote "an ideal impression of themselves or their practice" (p.253). The latter is more likely in an AI which seeks to maintain a positive focus, but rather than being problematic AI seeks to embellish the best of now for an even better future, so any such exaggerations enhance the study outcomes, aligned with the anticipatory principle which seeks to allow future images to shape current practice (Whitney and Trosten-Bloom 2010).

From a research ethics perspective my participant recruitment explicitly addressed the issue of people potentially feeling obliged to participate, making it clear that participation was entirely optional. However, my position within the organisation raised other considerations, including the importance of keeping my role as AMHP Lead and as researcher separate. As such any issues relating to practice inside or outside the workshops needed to be addressed by someone else within the organisation, ensuring for the duration of the study I remained more a co-researcher than a senior member of the team.

5.2.2 Familiarity

As a practising AMHP I am familiar with the experience of receiving a referral for an MHA assessment, and so arose the need to "'fight familiarity'" (Morriss 2016b, p.527); some elements of practice can become routinised and therefore may become invisible to the insider. In her auto-ethnography White (2011) conceptualised the need for the "problematization of taken-for-granted knowledge and day to day reasoning" (p.4). She achieved this through analysing her practice from a sociological perspective. Similarly, in the course of my study I found myself questioning my practice in new and ever-evolving ways. Inhabiting two worlds of practitioner and researcher simultaneously introduced marginality for me: Morriss (2016b) found herself moving from insider to 'marginal native' through her data analysis, yet for me this happened much sooner. By focussing more closely on my practice I noticed my practice change, much like the principle of simultaneity in AI, where "change occurs the moment we ask a question" (Whitney and Trosten-Bloom 2010, p.55). As soon as I started to ask myself how I made decisions at the point of referral for an MHA assessment, I started to scrutinise my own practice more closely, reflecting in action (Schön 1987) to a far deeper level than ever before. I referenced Polanyi (1966) earlier in this thesis and his concept of tacit knowing, where we may know a person's face but be unable to describe it. Extending this analogy, as soon as I started to ask the question of decision-making at the point of referral for an MHA assessment, I started to try to describe the features of the person's face; I started to look at the referral in a new way, reshaping my practice while making these decisions (Schön 1987). In so doing my "conception of the entity [was] destroyed" (Polanyi 1966, p.18); I struggled to view any referral for an MHA assessment with clarity, increasing my uncertainty. Yet such deconstruction helped to "supply material for a much deeper understanding" (Polanyi 1966, p.19). I began to appreciate more acutely why I found this decision hard; it is a

decision filled with contradictions, much like the detention decision itself as explored in my literature review.

When I found AI I started to feel enthusiastic about conceptualising this decision and its inherent complexity and contradiction positively rather than negatively; my study brought me to a place where I felt I inhabited neither world of practitioner nor researcher fully; my practice moved away from operational norms, yet my research endeavour felt somehow peripheral in academic terms, more 'practitioner research' than 'academic research'. Mendenhall (2007) considered the transition from practitioner to researcher, focussing on role discontinuity as a central concern:

> "by adopting the new role of researcher [practitioners feel] that they are betraying the role of the practitioner" (p.284-285).

This describes clearly my experience at the beginning of this research journey. Mendenhall (2007) suggested the easiest route is for practitioners to "redefin[e] the social work self to fit into the researcher role" (p.286), but she cautioned that this makes reconnecting with practice difficult (Mendenhall 2007). Mendenhall (2007) proposed a model of transition based on compromise:

> "Role bargaining requires compromises between the values, characteristics, and skills of the two conflicting roles" (p.286).

Rather than rejecting my position as a practitioner and attempting to delve further into a researcher identity, I found it liberating to accept my marginal position in both research and practice worlds; as a practitioner I used my research endeavour to develop practice positively through AI, while as a researcher I used my practitioner status to design a study that was meaningful to practitioners. In this way I used AI to merge research and practice, reducing the conflict between the research and practice roles and therefore avoiding any necessity to compromise as suggested by Mendenhall (2007).

The issue of familiarity potentially impacting data analysis becomes an inevitability with AI. However, embracing a collaborative approach it is the participants who interpret the data. As Bellinger and Elliott (2011) highlighted:

> "We were facilitators, strategic planners and communicators whose own interpretations had less validity than those collectively arrived at" (p.719).

The data generated through AI is subject to analysis from the group. The subjective experience of the group members is less a barrier to objective interpretation and more a necessary requirement for meaningful exploration of the experience of interest.

> "One of the most important guiding factors in the analysis of the data was that the language and focus remained grounded in the language and meanings of the participants. This avoided the analysis representing a form of 'academic hijacking' by the researchers whereby issues which had been presented clearly and simply by the participants were turned into something overly conceptual, abstract or academic (or as one participant said 'gobbledegook')" (Carter et al. 2007, p.531).

There is something *anti*-research in this position, for an impartial analysis of the data is the antithesis of what is desired; AI analysis remains in the practice domain and as such has far greater potential to hold meaning for practitioners than research subjected to abstract conceptualisations of practice. Data analysis in AI is collaborative between participants and following the principle of wholeness becomes a synthesis of the varied stories of participants (Whitney and Trosten-Bloom 2010). Empowering participants to define their reality is consistent with social constructionism.

5.3 Rigour

Positivist research seeks to uncover an objective reality, and so methods are developed to uncover this truth without the researcher affecting the findings in a subjective way. Notions of reliability and validity are utilised to measure the effectiveness of such research to uncover this objective reality. It will be clear by now that in my view when AMHPs receive a referral for an MHA assessment they are not seeking to uncover the truth; the process they engage in is interpretive. As Emden and Sandelowski (1998) highlighted

> "qualitative research is distinguished by complexities and nuances far beyond those capable of being captured by traditional usages of reliability and validity" (p.209).

In a later paper Emden and Sandelowski (1999) rejected criteria measuring validity and reliability in qualitative research, suggesting a criterion of uncertainty, that outcomes will be "tentative at best" (p.5). Such a position emerged from Sandelowski's (1986) opinion about the artistry of qualitative research. She later developed this notion further into the metaphor of taste, "the aesthetic sensibilities that play such a key role in evaluating objects of any kind" (Sandelowski 2015, p.86). I find notions of artistry and taste compelling as ways of framing research because like England (1986) I view social work in much the same way. Conflating research with practice helped me to feel more at home in this venture. Porter (2007) cautioned against such interpretations at the expense of accuracy about the 'something' being studied. For him:

> "It is the relationship between knowledge and practice that provides the key to judging research. If the point of nursing research is to inform practice, it is of paramount importance that those acting on the basis of the knowledge it provides

> are confident that it accurately describes and explains the issues being addressed" (p.83).

This study sought to achieve this through its participatory approach; this is a key strength of AI as a method for researching practice, for it is the participants who describe the issues being addressed.

> "With increasingly 'deep" participation there is a movement towards relinquishing control and devolving ownership of the process to those whom it concerns" (Cornwall and Jewkes 1995, p.1669).

Adopting AI situates ownership with the participants; in so doing the results inspire practitioner confidence in their accuracy, and in so doing rigour is enhanced. The influence of pragmatism is evident, where concepts of reality may be ceded to the applicability of the findings to practice.

Reed et al. (2002) used nominal group technique as a method of group-based data interpretation to enhance rigour. Nominal group technique is

> "a group meeting in which a structured format is utilized for decision making among individuals seated around a table" (Van de Ven and Delbecq 1974, p.605).

Søndergaard et al. (2018) clarified participants "have expert insight into a particular area of interest" (p.2). In this way the technique appeared very well suited to this study where only those with expert insight into the experience were involved. Pippard and Bjorklund (2003) added

> "each member is given an equal voice, minimizing the potential for a select few to dominate the group" (p.108).

This was important for embracing the AI principle of wholeness, where differing views are important.

The use of structure in the process of data analysis added transparency and auditability to the process enhancing rigour. Sandelowski (2015) however highlighted the

> "impossibility of transparency, of articulating or accounting for all aspects of one's engagement with an object" (p.91).

The goal was to get as close as possible to transparency through a participatory approach:

> "in which the visibility of the researcher and the transparency of their intentions are significantly greater than in conventional research" (Cornwall and Jewkes 1995, p.1672).

As a researcher and a practising AMHP I knew I would influence the results of this study. Indeed, as discussed in relation to my status as an insider, the process of completing this study had also had an influence on me as a practitioner. This is what has been termed as reflexivity:

> "a *way of looking* that gazes outward at what is taking place while sustaining an inward gaze at the looker" (Probst 2015, p.46).

I could not remove myself from this research, but I could seek to maintain transparency about my subjective position.

> "Because the process is so idiosyncratic, the researcher cannot know in advance what will require reflexivity or what tool will serve best, so it may be difficult to build reflexivity into a study design" (Probst 2015, p.38).

My experiences and perspectives will have influenced the results of this study, my narrative had a place in the data as part of the whole, but the whole was a synthesis of all experiences in line with the wholeness principle of AI (Whitney and Trosten-Bloom 2010). To achieve this, I embraced the participatory aspects of the methodology, including in data collection and analysis; however, to achieve transparency of my influence I also became a participant. Formalising my experience into the research process made my influence explicit. Writing from an autoethnographic perspective, Ellis and Berger (2003) described interviews as a

> "sea swell of meaning making in which researchers connect their own experiences to those of others" (p.471).

While I didn't unilaterally conduct interviews, I did facilitate workshops with participants and so could not stay out of the sea completely; if I sought to remain out and therefore claim objectivity I would fail; jumping in and immersing myself in the process was a more honest approach.

The knowledge generated from this study is about the unique experiences of the AMHPs participating. The results are subjective to the experience of the participants, yet as the first study into this AMHP decision the knowledge generated is valuable as a way of beginning to understand the experience. Hughes (2011) carried out a unitary appreciative inquiry into the experiences of five student social workers approaching qualification, recognising that we can

> "learn from these unique experiences to enhance our understanding of a particular context" (p.697).

This study sought to learn more about the context of AMHP decision-making at the point of referral for an MHA assessment by drawing on the unique experiences of the participants.

5.4 Ethical approval

Ethical approval was sought from the Bournemouth University Ethics board and this was approved on 3rd December 2019 (Ethics ID 27945). The relevant Local Authority then additionally approved the study on 21st January 2020. This ethics approval was amended and approved twice further during the course of the study (15th July 2020 and 5th November 2020) in response to the study taking place during the coronavirus pandemic.

5.5 Participants

Nine participants agreed to take part in this AI, including myself, each giving themselves a pseudonym (see Table 3).

Table 3: Participants

Pseudonym	**Gender identity**	**Ethnicity**	**Age**	**Experience**	**Profession**
Rhoda	Female	White British	51-60	11 years +	Social Work
Jean	Female	White British	41-50	6-10 years	Registered Mental Nurse
Edie	Female	White British	61-70	11+ years	Social Work
Charlie	Male	White British	41-50	11+ years	Social Work
Jake	Male	White British	51-60	11+ years	Social Work
John	Female	White British	51-60	11+ years	Social Work
Frank	Male	White British	51-60	11+ years	Social Work
Sián	Female	White British	41-50	<2 years	Social Work
Ro	Female	White British	51-60	11+ years	Social Work

As you can see from Table 3 all participants were between 41 and 70 years old. This is a slightly older demographic than has been recorded nationally where only 74% of AMHPs fall into the 40 plus age range (Skills for Care 2022). All participants were white British compared to 80% nationally (Skills for Care 2022). Six were female (66%) and three were male (33%) compared to 74% female nationally (Skills for Care 2022). Seven had over eleven years' experience working as an AMHP (77%), one with between six and ten years, and one with less than two years. This is a much higher level of experience than a comparable measure of the duration of experience of AMHPs in the adult social care sector nationally, where only 29% had over ten years' experience (Skills for Care 2022). Eight participants (89%) were social workers and one was a nurse, compared to 95% social work AMHPs and 4% nurse AMHPs nationally (Skills for Care 2022). Given the small number of participants involved the sample is remarkably representative of AMHPs nationally, the most striking anomalies being ethnicity, age, and experience, with the participants all being white British between 41-70-years-old and predominantly with more than ten years of experience as an AMHP.

Across three teams there was a total population of sixteen people eligible to participate in this study, nine of whom chose to do so. Eight of those participants were part of the same team, myself included. In fact they represented the entire population of that team. There are two possible reasons for this: the first is that those participants working in the same team as me felt some level of obligation to participate; or secondly that team had an interest in the research topic that was not replicated in the other two teams. My sense is that it was a combination of these two factors. This AI is founded upon social constructionism, a philosophical position that conceptualises reality as a construct formed between people through communication (Berger and Luckman 1966). As part of the team I have developed an interest in the point of referral for an MHA assessment. This may be something specific to me or it may be the result of a shared interest within the team. It is not possible to extrapolate where the interest in this experience emerged from, but understood through social constructionism this interest became a shared understanding of the reality of AMHP practice within the team. In addition my interest was well known to my immediate colleagues, something identified by Mercer (2007) as undesirable but in this case unavoidable. My views were known to the team, and so through the lens of social constructionism it is likely that the team felt motivated to research the topic due to an interest developed and fostered within the team.

It is not possible to rule out that in addition to this shared understanding people may have felt some level of obligation to take part. The participant information sheet made it clear there was no obligation to contribute, but it seems unlikely this entirely removed all sense of obligation. As AMHP Lead in the team, with a passion for this subject, my colleagues may have wanted to show their support, something earlier identified by Probst (2015). What is perhaps more difficult to understand is why there was only one participant from the other two teams. The above rationale may similarly explain this: the sense of obligation or support for my interest was absent from those teams; or the interest in the research topic was less in those teams. Again both those possibilities may be related, with social constructionism a way of framing an understanding of these issues. There were in fact three other people who contacted me to explain they were interested in participating but could not do so for different reasons, highlighting the range of issues relevant to deciding about research participation is broad. Interest in the experience was more widespread than within my immediate team, with those in other teams likely to feel less obligated to support my research interests, yet many other factors can prevent an interested party from participating in research.

5.5.1 A decision about additional participants

Following the appreciative interviews participants were asked if they felt they had enough data or whether they felt they needed to interview additional AMHPs not involved in the workshops. At this point in the study the participants were working toward mapping the positive core of the decision at the point of referral, and so while additional participants would have needed experience as AMHPs they did not need to be in practice and they did not need to work in the same local authority. Because this stage was about illumination not change these factors were less important. The key was whether the participants felt they had enough data to progress through to mapping the positive core of the decision. This final element of sampling was left to the participants themselves and may be based on what Patton (1995) grouped together as emergent or analytically driven sampling strategies. For example, participants may have wished to speak to specific AMHPs they knew and respected to incorporate their views into the data (such as in snowball sampling); participants may have felt the data generated was insufficient and required further exploration (such as with saturation sampling); or participants may have wished to add data to elaborate on the data already generated (such as with illumination and elaboration additions). A separate interview-only participation information sheet was developed for

this purpose. Participants would have been approached directly where their identity was known (such as if snowball sampling is adopted by participants) or indirectly through local AMHP leads. Interviews would have been conducted by participants based on them volunteering. Interviews may have taken place in person or over the phone or internet depending on practicalities. In the event the participants chose not to interview anyone not involved with the study, partially due to time constraints and partially due to a feeling that those already involved understood the philosophy, and this may not be shared by those who had not had the same opportunity to nurture an appreciative mindset.

5.6 The study

This AI followed the full 4-D cycle based on tools and methods described by Whitney and Trosten-Bloom (2010). Figure 1 illustrates the full process this AI followed.

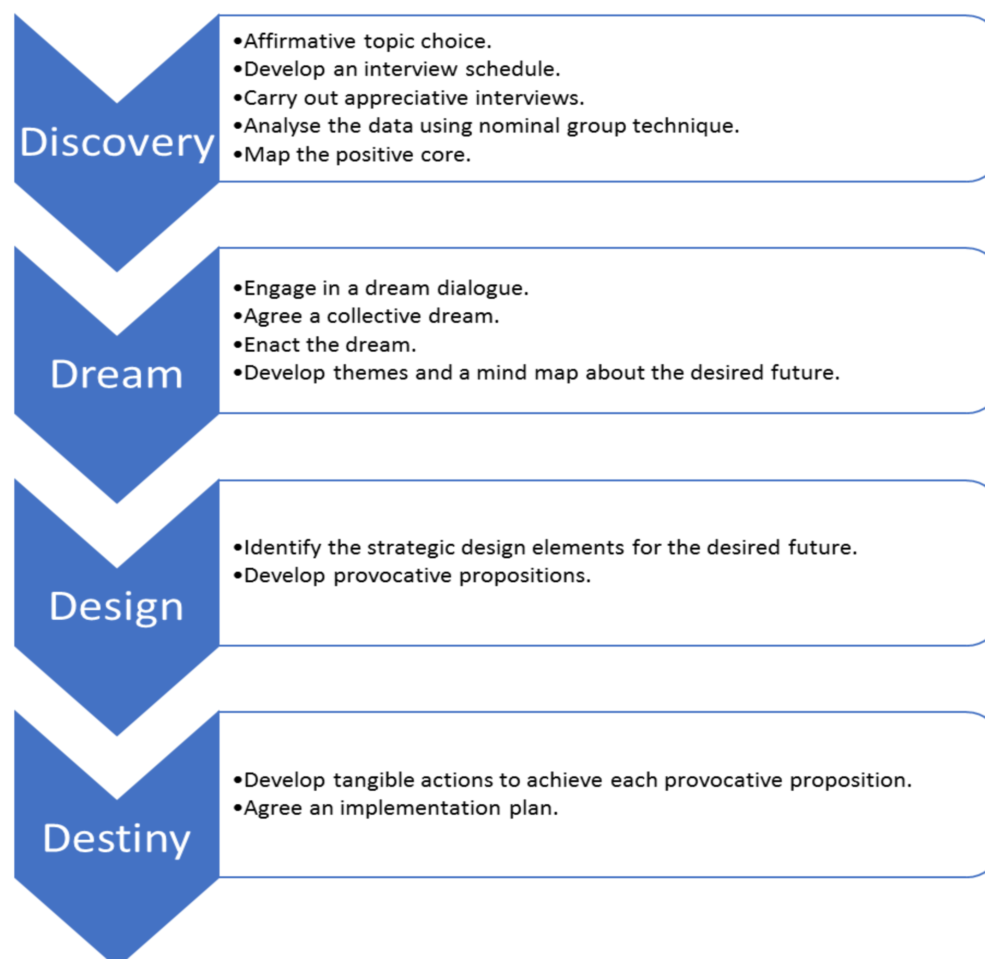

Figure 1: Appreciative Inquiry process

Embracing the collaborative spirit of AI, the study was designed around three one-day group workshops one-month apart. In the event four workshops were held due to the

process taking longer than expected. I had thought three full-day workshops were the minimum required to achieve the desired aims, and full-day attendance rather than a greater number of shorter sessions was intended to facilitate participant attendance: whole day sessions allowed for the organisation of appropriate service cover allowing participants the time away from their usual duties. This approach to AI most closely resembles what Whitney and Trosten-Bloom (2010) termed “Progressive Appreciative Inquiry Meetings” (p.45), in which “a group or team works through the 4-D Cycle” (Whitney and Trosten-Bloom 2010, p.45), albeit adapted into fewer full-day meetings rather than twelve shorter meetings for operational reasons. The workshops were held in a geographically central location for participants, away from their usual workplaces. The venue chosen was familiar to participants from training sessions provided by the service. What follows is a description of both the research process as intended, and some reflections on what happened and how the study design changed through the collaborative process adopted.

5.6.1 Workshop one: Discovery

I began with an introduction to AI: the eight principles, 4-D cycle and a focus on the importance of topic selection (Whitney and Trosten-Bloom 2010). This was based on my methodology chapter (see appendix five for presentation materials). There were questions about the methodology which was positive as from the start the participants were clearly interested in what we were about to do.

Participants were then paired and asked to conduct mini-interviews between themselves. This began the process of the affirmative topic choice. People had a lot to say which was good for data collection. It was great to see people engage in the topic and share my enthusiasm. My former concerns about this experience not being much of an issue to anyone else were quickly dispelled.

Following the mini-interviews each pair formed a small group with another pair and on a round-robin basis stories from the mini-interviews were shared by the paired partner, highlighting common themes and determining factors between the stories that contributed to high point experiences. Discussing the mini-interviews in small groups highlighted how everyone embraced the affirmative stance, and a lot of stories of positive practice were shared and celebrated.

The whole group then discussed one or two stories from each small group, highlighting themes between the stories. These themes were recorded on flipchart paper. This process flowed well, again the positivity shining through in abundance and further contributing to a positive atmosphere and a genuine celebration of the role. Participants were commenting about how good it felt to discuss practice in this way and have the opportunity to reflect positively. The themes seemed to emerge effortlessly and wove together well.

The group were then reoriented to the central qualities of affirmative topics before agreeing three to five affirmative topics “extrapolated both from the stories and the master list of themes” (Whitney and Trosten-Bloom 2010, p.138). This took much longer than expected and, well past when we were due to stop for lunch, we had not managed to generate any affirmative topics. At this point it became clear we could not hope to fit in everything planned for the day. I raised this with the group, validating the importance of what we were doing and how central the affirmative topics were to the rest of the study. The participants agreed it was important to get this right and therefore we should abandon the idea of completing the first workshop at the point I had anticipated. The plan had been to complete the appreciative interviews in the first workshop. I proposed we carry out the interviews between workshops one and two, and all were happy to do this to afford more time to work through everything thoroughly. This was a great relief at this point as we were over an hour behind time. Removing the interviews from the workshop saved two and a half hours so I was able to feel much more relaxed moving forward. We had lunch and returned to the affirmative topics. I suggested we keep them short and simple, getting as many suggestions down as possible then considering integrating them and extending them afterwards. Everyone agreed simplicity was desirable, and in fact approaching the affirmative topics in this way proved much more productive. After some revisions we finalised some really positive statements that seemed to encapsulate our themes well.

The discovery process began with developing the questions for the appreciative interviews: I began with an introduction to appreciative interview questions (see appendix six), which would include a title, lead-in statement, then two to four questions exploring the topic. Then as a whole group participants were asked to turn the affirmative topics into appreciative questions in preparation for the interviews.

All participants were experienced professionals proficient at eliciting a narrative from service users, therefore while other appreciative inquiries may provide more detailed instruction on interview technique this was not necessary in this study.

There was a consensus among the group that the affirmative topics were self-explanatory and so they did not want to generate lead-in statements. This appeared a deviation from the suggested approach, but I reminded myself that the study was co-operative, and the participants were guiding progression as much as me. Getting the group to consider statements they did not feel were necessary was not something I wanted to try given the positivity and motivation they were displaying, and this would hardly have been participatory. We proceeded therefore to form the questions without lead-in statements. After a time, people expressed a strong preference for simplicity again with the questions. All agreed that as AMHPs we have a lot to say, and so asking a broad simple question was better than trying to think up something more complex. The consensus was the broader the question the better the narrative, and similarly people wanted to keep the questions down to the bare minimum because they felt AMHPs would provide in depth and lengthy responses, as had been the case with the mini-interviews.

By the end of the day we had nine questions reflecting our four affirmative topics, all simply stated. People were evidently tired by this point and the workshop was brought to a close. We had a discussion about whether to just interview each other or bring in other people. There was some concern about fitting in extra interviews, and some expressed a view that those present at the workshops knew much more about what we were trying to achieve, and involving others may not enhance the quality of data. There was a sense of ownership over the process and people felt quite personally about what we were doing. There were concerns that others might not understand, reflecting my concerns throughout this PhD. It was warming to see how the participants had gained such a sense of connection to the study, and all agreed they would prefer not to introduce other people. Participants agreed to interview each other in the pairs they had formed for the mini-interviews.

The plan had been for participants to be asked whether they preferred to be paired to interview each other using the interview schedule they have developed, or whether they would have liked to address the interview schedule as a whole group. However, as the interviews could not take place during the workshop due to time running out, it was not possible to offer this suggestion.

My intention was to ask participants to think about some key messages, and to draw out some compelling quotes highlighting examples of the best from their interviews for discussion at the next workshop, however in the event I forgot to request this.

Following the first workshop, I looked back over the appreciative interview questions and felt three of the nine questions were framed somewhat neutrally. I reflected this could have been due to the questions having been developed at the end of the day when participants may have been feeling tired. I amended them with the additions of *where this went well*; *can you give some positive examples of;* and *in positive terms* (see appendix seven for full details of the changes made). I sent the amendments out to participants to check if they were happy with the changes, to which participants responded they were. This may be an example of my influence over the data collection, but the essence of the questions remained unchanged, rather the appreciative element added was designed to maintain a greater degree of fidelity to the appreciative basis of the methodology.

5.6.1.1 Reflections on day one

As both researcher and participant I was aware this would be a complex process, but I had thought being a participant would solve most of the issues. It was never going to be possible to keep my views out of the workshops, not least because other participants would know my views from our work together. This seemed to work well, and I felt like one participant, and not an especially dominant one. That said I also had to facilitate the day, working through the design of the study and adhering to the AI approach. This introduced some unanticipated complexity, for I had to influence the data collection on one level as a facilitator and on another as a participant. I needed to contribute my views as a participant, while at the same time guide the process as a facilitator. There were times it felt very difficult not to guide the data toward my preference as a participant. One clear example was the mention of time as a theme which immediately enthused me, yet as we tried to define this concept sometimes suggestions were made that did not use the word time. I contributed by highlighting the importance of including the word itself, as I felt the central meaning could be lost without it, and while I believe there was a consensus about this, it may be that my position as facilitator enabled me to exert a greater degree of control than any other participant.

Reflecting afterwards I feel my contributions were not domineering. Participants engaged well in discussions and took some key decisions that deviated from my conception of what we would be doing. One example was the decision not to use lead-in statements; another was the decision to minimise the number of questions on the interview schedule; a further was the decision not to interview people outside the workshops. These were all key decisions made by the participants, demonstrating they were not deferring to my opinion.

5.6.1.2 Appreciative Interviews

I interviewed two participants between the workshops because one participant was called away to a family emergency and was not able to carry out his interview or attend the next workshop. I noticed in both interviews the use of negative terms and so I had to reorient interviewees to a positive mindset. I was conscious again of my role as researcher and not wanting to influence their answers, but I needed to balance that the interview was more an appreciative conversation, so I did contribute at times. I perhaps withheld a little, fearing exerting an influence on what was being said. Afterwards I reflected that other participants may have felt freer to engage in a narrative rather than be constrained by fear of undue influence.

5.6.1.3 On philosophy

AI is founded upon social constructionism, where reality is created among groups of people through communication. This concept itself was made real to me through the process of the first workshop and the subsequent appreciative interviews. There were moments I heard others put words to thoughts and feelings I had that I had hitherto been unable to define. Equally, the process of vocalising my experiences and hearing others share and validate those experiences sought to create a sense of reality about decision-making that had previously escaped me. Yet I was also aware from ongoing experiences that the reality we were creating was not universal; that other people, even other AMHPs, may not share the same perspective. The participants recognised this also in their desire to keep the data collection within the workshop participants, rather than seeking to interview people not involved in the workshops. There was a sense of not wanting to bring in the opinions of others where this may differ from those of the group. So we were engaged in a world of our own making, relevant to us and hopefully holding meaning for others as well but certainly not in a positivist sense of objective truth.

5.6.2 Workshop two: Discovery and Dream

We started the day with some reflections so far. One participant highlighted how it was nice to be focussed positively on our role, and another said that for her it validated that it's okay to share dilemmas with colleagues. Another reflected on how different our decision-making is to the medics, and this validated the importance of the role for her. I reflected my experience of world-making, where words were put to ideas I had not fully formulated, and my views were echoed by others, validating them and making them more real to me.

The group was divided into small groups and on a round-robin basis each person was asked to convey the key messages highlighting best practice from their interviews. This took a little longer than anticipated because I had forgotten to ask people to consider this in advance. Each group was then asked to engage in a deeper level of dialogue about these key messages to arrive at some shared meanings between the stories. This process was lengthy because the interviews generated a lot of data. I quickly understood my time schedule for the day would be unrealistic again, this time accepting there was nothing I could do about it and embracing that more data and more discussion was taking place than I had anticipated, and that this was a positive thing.

The whole group was then reconvened, and each subgroup was asked to present its shared meanings. Collective shared meanings were agreed by the whole group. Agreeing the shared meanings seemed to flow easily.

The task of the whole group was then to map the positive core of AMHP decision-making based on these shared meanings. Artistic means were encouraged to express this, though ultimately the participants were able to decide how best to represent the positive core. Participants were provided with large pieces of paper and coloured felt pens. I had felt worried people would not want to engage in any artistic activity and was concerned about what their response would be. In the event my concerns were not founded, and people quickly started offering ideas for the map. I had also expected us to go through draft versions, but in fact we were able to build on one version through to completion. A lot of ideas were shared and the map we produced felt to me like a good representation of our “positive core”. One participant reflected that despite never liking group activities she found this whole process valuable and rewarding, which surprised her.

Moving on to dreaming, participants were asked to quietly reflect upon the following focal question:

> *It’s 20-years from today, legislation and resources remain largely the same but there have been changes that have improved the way services work with people with mental illness. What’s happening now when someone reaches a crisis point in their mental health? How are AMHPs approaching the decision about whether to proceed with an MHA assessment? What decisions and choices did AMHPs make to pave the way for these changes?*

The plan had been to complete this in small groups as part of a dream dialogue, seeking to reach a consensus about what this dream would be. Small groups would then share their dreams with the whole group, collectively agreeing the dream. However, we spent time on this individually then moved straight to a whole group discussion to seek to clarify the collective dream. This took us to the end of the day, about two thirds through what I had planned we would achieve. I was also conscious being the end of the day people were becoming tired and we would need to revisit the collective dream at the next workshop to ensure this was as accurate and comprehensive as we would like before proceeding to the next task.

During the day I had highlighted the possibility of a fourth workshop which if necessary, people were open to. This took the pressure off completing the activities for the day and enabled us to focus on working through the activities thoroughly.

5.6.3 Workshop three: Dream and Design

Workshop three coincided with the second lockdown in England due to the global coronavirus pandemic, leading to a shift to an online platform subsequent to participants opting for this method rather than a delay, and subsequent to an ethics amendment. There were some technical issues at the beginning of the session but once everyone was in the meeting the group seemed comfortable with the platform. By this point participants had become accustomed to online meetings, and having formed as a group already the shift to online appeared to work well.

We started with a reminder of the ground rules and explanations of how to send me a private message for an individual conversation if needed. Then I did a recap of workshops one and two. We then looked again at the collective dream and spent time building on this as a whole group.

The plan was then to encourage participants in small groups to consider enacting this dream as a play, each adopting a role within a fictitious scenario of their own construction containing the elements of their collective dream. Alternatively, they could be asked to creatively represent their dreams. The purpose of this was to use creativity rather than language to “open doorways to… intuitive ways of knowing” (Whitney and Trosten-Bloom 2010, p.183). We considered the group small enough to do this as a whole group, and from one of the suggestions arising in the collective dream decided to enact a ‘blue light’ meeting, a protocol developed by NHS England targeting people with learning disabilities or

autism, and aiming to prevent the need for admission to hospital by convening an urgent meeting to explore alternatives with the person, their family and a range of relevant agencies involved (NHS England 2015). In advance of the AI workshops I had summarised an example referral based on a real scenario for use during the workshops should a scenario be needed. This scenario was developed to be used at any point to generate discussion. I suggested this scenario could be used as the basis for the blue light meeting, to which the participants agreed. My influence in the production of this scenario is self-evident, but equally it felt like a natural progression from the earlier discussions.

The creative enactment of a blue light meeting was conducted as a whole group, and suggestions flowed easily from participants. The plan was then to ask participants to agree common themes to their collective desired future, first in small groups then as a whole group. We decided to do this as a whole group as we felt it was not necessary to split the task. We then developed a mind map of themes and issues relating to our desired future as a whole group.

Participants were then asked in small groups to consider what design elements of the AMHP service, such as policies, procedures, and accepted working practices, impact upon achieving the desired future. Small groups were then asked to collectively compare these elements and agree a final set of strategic design elements as a whole group, specifying ideals for each design element.

Participants were given guidance that provocative propositions should be expressed as a future ideal that already exists; based on best practice as identified in the discovery phase; stretch practice beyond what is currently achieved; move practice to where they want it to be (Whitney and Trosten Bloom 2010). Participants were then asked to develop provocative propositions by separating into small groups. The plan was for each small group to discuss one design element, but participants preferred to have two larger groups and discuss two design elements each. Each group developed their provocative propositions for their design elements. Groups then shared their provocative propositions and a consensus was sought about the wording. This concluded the third workshop, with an agreed fourth workshop being added to complete the implementation plan.

5.6.4 Workshop four: Destiny

The last workshop was held online again, and was just half a day, focussing on an implementation plan for each provocative proposition. The group were divided back into

small groups so that each group could develop tangible actions to achieve their provocative propositions, which they then presented back to the whole group. The whole group was then asked to agree upon the action points across all provocative propositions.

In small groups an implementation plan was then drawn up from each action point; the action points were divided equally between the groups to achieve this. Finally, the small groups fed back their implementation plan to the whole group, resulting in a finalised implementation plan across all actions.

5.6.5 Legacy meetings

> “The cyclical nature of the AI process points to the iterative nature of AI: It is not a linear process that starts and then stops when it is completed” (Reed 2007, p.31).

Acknowledging this dimension of AI participants were offered follow-up meetings to discuss how the process of this AI had impacted their practice. The timing and number of follow-up sessions was responsive to the preferences of the participants, with two meetings being held in total; one three months after the completion of the study and a second at nine months.

Chapter 6 The impact of coronavirus

This study into AMHP decision-making at the point of referral for an MHA assessment has taken place during the global coronavirus pandemic. In this chapter I hope to convey some of the multitude of ways this has impacted on the study. I have structured the chapter to represent three phases of this research journey: pre-data collection; the data collection window; and post-data collection. I write this chapter as a novice researcher negotiating the shifting government policy and advice regarding the pandemic; a practising social worker and AMHP continuing to work through the pressurised period of lockdown; and a father of a school aged child juggling the demands of home schooling with work and study.

6.1 Pre-data collection

The UK government announced lockdown on 23rd March 2020, with schools having already closed on 20th March 2020 to all but vulnerable children and children of keyworker parents. At this point in time my data collection via group workshops was due to commence on 22nd April 2020, something which quickly became clear was not going to be possible. Delaying data collection was initially a relief as my focus in the weeks preceding the workshops would have been on preparing for the workshops, something I suddenly had less time to achieve due to the school closures and home schooling. The subsequent three months became a lull in my research journey. I had little time or energy for my PhD. Increasingly, work had become more demanding, with less staff available for face-to-face contacts those of us who continued were diverted to AMHP duty work every day. An initial lull in referrals for MHA assessments soon passed and assessment numbers gradually increased to above average levels.

6.1.1 Local policy change

The mental health trust providing mental health care in the area where I work introduced a new policy during the pandemic to guide professionals thinking of referring for an MHA assessment. The policy suggested “new levels of scrutiny and challenge… to avoid admission” (NHS Trust A 2020, p.2), and “new thresholds for detention” (NHS Trust A 2020, p.2). Staff were encouraged to “balance human rights considerations, including the risk of spreading infection” (NHS Trust A 2020, p.2). The overall aim was “to reduce and avoid hospital admissions” (NHS Trust A 2020, p.2). The policy acknowledged the increased risk of hospital admission during the pandemic, specifically the risk of contracting coronavirus, and encouraged community alternatives to admission (NHS Trust A 2020). Procedurally all

referrals had to come through the Intensive teams (teams already in place and specifically tasked to work intensively with people at home to avoid hospital admission) and be agreed "at the most senior level possible" (NHS Trust A 2020, p.2). There are some aspects of this policy that are worthy of reflection, particularly given the experience of interest in this study. Those I have separated into process, decision-making, and risk.

6.1.1.1 Process

Section 13(1) MHA 1983 requires an AMHP to "consider the patient's case", but the source of information from which their consideration commences is not defined. This policy sought to define a process, narrowing referrals to Intensive (Crisis) Teams and ideally senior members of those teams. The AMHP was not asked to avoid referrals from other sources, rather the policy sought to encourage referring staff to follow a process rather than refer directly. As an AMHP, a referral from any source where the AMHP believes intervention from the Intensive team may be a viable less restrictive alternative to admission would likely result in signposting to that team, but essentially the policy encouraged potential referrers to refer to the Intensive team first, rather than this being an AMHP recommendation.

When the MHA 1983 was being revised prior to the 2007 amendments, the government initially included a process whereby requests would be made to the responsible National Health Service (NHS) body, who would consider the evidence and determine whether the conditions for detention "appear to be met" (Joint Committee 2005, p.109), following which an examination (an MHA assessment) would be arranged if sufficient evidence was obtained. This was later scrapped in favour of amendments to the MHA 1983, but it seems to closely resemble what this policy sought to achieve in that regard: specifically, to place the NHS body at the forefront of any potential MHA assessment referral. The Draft Bill in 2004 did not include an AMHP in the process, whereas clearly the MHA 1983 places the legal duty to consider the case with the AMHP (s 13(1) MHA 1983). This policy then did not seek to remove AMHP involvement, rather it sought to limit their involvement as far as possible. With the focus of the policy being on avoiding admission, the implicit presumption could have been that AMHPs were likely to agree to assess people when it was not justified or necessary. This implication is significant for this study of AMHP decision-making at the point of referral for an MHA assessment, both in terms of what it says about AMHPs, but also the importance it attaches to decision-making at the point of referral for an MHA assessment.

6.1.1.2 Decision-making

Leading on from process, the policy sought to encourage greater scrutiny of possible referrals before they are made, encouraging deeper levels of consideration before contacting an AMHP. This could represent a sharing of the responsibility for decision-making at the point of (potential) referral for an MHA assessment, although it appears to exclude the AMHP. Had the policy been established collaboratively with the Local Authority AMHP service, it may have been more inclusive, potentially enhancing decision-making at this crucial point.

6.1.1.3 Risk

It is interesting this policy acknowledged the risk of admission in terms of coronavirus, when other risks of admission were not acknowledged. The physical health risk associated with coronavirus, specifically death for some, was sufficient to cause NHS Trust A to make every effort to limit this risk as far as possible. By extension, other risks such as the impact upon people's self-esteem when detained, their physical safety on the ward, or harm from treatment (Smith 2001; Morriss 2016a) were not afforded such protection.

6.2 Data collection

I reconsidered my research design in light of coronavirus and the uncertainty about whether it would be feasible for groups to gather for research activity. I was however mindful that research suggests face-to-face focus groups produce more topic related data than online focus groups (Abrams et al. 2015). Nevertheless, the workshops were redesigned for online, but in the first instance as people were being encouraged to return to workplaces, I gave the option of face-to-face workshops or online sessions to the participants. All participants agreed to participate via either medium, but their preference was to meet face-to-face. Given all participants were essential workers and regularly attending the office for work, including continuing face-to-face contacts, I proceeded with my original study design of three one-day group workshops.

After obtaining updated ethical approval on 15th July 2020 via an amendment to my original approval (Ethics ID:27945) and agreement to proceed from the Local Authority employing the participants on 8th July 2020, I was left with only two areas of uncertainty: The venue I had hired was run by a private organisation who were not yet agreeing to hire out their premises. I was however able to move my booking to days where no other groups had hired the venue and therefore change the room I had booked to a much larger hall capable

of accommodating up to twenty people socially distanced at two metres. The second variable was any future government guidelines restricting groups from meeting. In fact, two changes were introduced in the final weeks before the first workshop: firstly, was the 'rule of six', whereby no more than six people would be permitted to gather. This however excluded the workplace so did not prevent the workshops from proceeding. Secondly, people were encouraged to work from home if possible. Again, not preventing the workshops from proceeding. Nevertheless, I was acutely aware that the government could amend the rules at any time impacting upon the study.

The decision to proceed face-to-face, notwithstanding made jointly with the participants, continued to feel uncomfortable. Proceeding in this way was underpinned by a desire to create a rich social environment thereby generating the best possible data, yet group gatherings were increasingly frowned upon socially. Organised groups with covid secure measures in place continued to function however, and I needed to remind myself I was following the appropriate guidelines, including social distancing, face coverings when not seated, use of hand sanitiser (provided to participants) and anti-bacterial wipes for surfaces and shared materials. Staggered breaks from other groups using the facility formed part of the plan but in the event, there were no other groups. Similarly, the use of separate entry and exit points were not required as we were the only group using the venue.

Workshops one and two proceeded as planned however, two weeks before the third workshop England entered another period of lockdown preventing the third workshop from taking place face-to-face. Given the date was already arranged, with participants having allowed for this in their diary, together with the likelihood of a delay due to Christmas approaching if the workshop were to be reconvened, participants decided at this point to hold the workshop online rather than delay until such a time that face-to-face meetings would become permissible again. This required a further amendment to my ethics approval, agreed on 5th November 2020 (Ethics ID: 27945).

In the event the third workshop went well and a lot was achieved. A fourth workshop was however required to complete the destiny phase.

The last workshop was just half a day and focussed on an implementation plan for each provocative proposition. It had been two months since the third workshop and a lot had happened in between. Most significantly a new strain of coronavirus had spread through the country leading to a second wave of infections far higher than before, particularly

locally. There had been little incidence locally of coronavirus before this strain, but there was a surge in cases with all of the psychiatric wards on one hospital site having infected patients, patients we had detained were dying, and staff were being treated in intensive care. There was a tangible sense of fear and I was unsure if people would be able to focus on completing the study. However, in the event we agreed an implementation plan very quickly and with relative ease. It felt as though the thinking had already been done and we were just vocalising and finalising our conclusions.

6.3 Post-data collection

This study took place at an uncertain time for the team. A process of restructure had been initiated and a new model for the service had been developed. This was a top-down process, with little or no involvement from the staff, and as such there was a palpable sense of powerlessness and resentment toward the organisation. The new service structure was dependent upon the recruitment of a manager to take this forward, a post suggested for me but one which I felt disinclined to take given my concerns and those of the staff I worked with. This led to a period of delay which served to prolong a sense of uncertainty for all concerned. The manager position was advertised twice without any suitable applicants, by which point the combination of this process and the impact of coronavirus had delayed the process of change by eight months.

Despite the organisational changes afoot this AI had been designed and I wanted to persist with the study. The focus of the study being on professional practice I felt supported the rationale to continue: while the service was changing around us our practice was still important to us and highlighting the best of practice now and developing this further remained a worthy goal. I was aware there could be some clashes with the proposed organisational changes, but AI is also about identifying realistic goals within the organisational framework, so I did not consider the two processes necessarily being mutually exclusive.

During the workshops there were some comments about whether enhancing practice would be something valued by the organisation, with concerns that any recommendations about service design would be dismissed.

After the third workshop, with the destiny phase still to complete I was approached again to assume the management role, this time on a temporary basis. Some concessions were

made by the organisation regarding the new service, principally concerning the number of staff available each day which led to my acceptance.

Accepting the role of manager had some benefits in terms of implementing the action plan from the study, and these changes started during the study rather than at completion. Participants were approaching referrals for an MHA assessment following their ideals from the study, and as manager I was able to implement the key ideas of the *triage AMHP* role and the *AMHP s 13.1 report* prior to this being finalised with the participants in the final workshop.

The service changes took place between workshops three and four, at the same time the second wave of coronavirus swept the country and a third lockdown was implemented. The coronavirus vaccine was also developed at this time and offered to health and social care staff locally. By now a year into the pandemic and with vaccinations underway a greater sense of optimism emerged. There were also benefits arising from the service changes that enhanced the ability of the service to implement the AI service design elements.

In accepting a temporary management position at a time of service change I increased my working hours and found little time for my PhD. Entering into a data analysis phase required mental energy that escaped me and as such progress was slow and I achieved little in the first six months of 2021.

Finally another change in my position occurred: an opportunity arose to lead the AMHP programme at a University, a position I applied for and was successful in gaining. I retained a part-time position as an AMHP in the Local Authority, but the move to a University setting offered me greater opportunity to refocus on my PhD.

Chapter 7 Findings

My intention with this chapter is to provide an account of this AI, presenting the process we followed, the data we generated along the way, and some additional evidence from interview notes to support the data and outcomes. Where there is a clear link to my literature review on ASW/AMHP detention decisions I will highlight this, alongside any other supporting theories already presented in this thesis. Additionally I will seek to highlight fidelity and deviance from the essence of AI, accepting however that there is no one way of conducting an AI (MacCoy 2014). Key themes and the contribution to knowledge from the findings will be identified and then developed further in the discussion chapter.

I will describe how our first achievement in this AI was to acknowledge that a decision does indeed need to be made at the point of referral for an MHA assessment. Participants at no point considered this decision to be routine or cursory. This is an important acknowledgement because in the introduction to this thesis I have highlighted how in practice those referring often seem to expect an assessment to be arranged without a process of decision-making at this point. The intricacy and essence of the decision are represented pictorially in the positive core map (Figure 28), described later in this chapter and constituting a central finding from this study.

I will show how participants felt a connection with the person referred was important to establish, often including meeting the person referred in advance of making a decision. Participants created the *triage AMHP* role and the *AMHP s 13.1 report* to promote the decision at the point of referral for an MHA assessment being valued by the organisation, giving themselves the opportunity to explore the relevant information and form the appropriate level of connection with the person and the situation to enable them to reach a decision. The notion of *changing gears and buying time* will be introduced, and then explicated in the discussion chapter as key themes from this AI, with the *triage AMHP* role being the space to facilitate a slowing down of a detention trajectory through risk analysis to then afford the AMHP the opportunity to explore alternatives to assessment and detention. This desire is at the heart of AMHP practice, and this study will highlight how AMHPs feel this central aspect of the role is achieved at the point of referral for an MHA assessment better than at any other point. As such this study will be the first to acknowledge and truly recognise the importance of this decision for AMHP practice.

Throughout this chapter I will seek to demonstrate how this AI has had a tangible effect upon those participating and on the service as a whole. I will illuminate how the focus on the best of practice in the discovery stage highlighted the best of how participants saw themselves, their socially constructed reality of best practice, inextricably linked to their dreams which may be less frequently realised but nevertheless represent what they were striving for. This represents the key strength in this AI, for the overall desire was to move practice in the direction participants wanted to see it move in, rather than dwell on problems and obstacles. The fact that participants implemented the central desire emerging from this study (the *triage AMHP* role and *AMHP s 13.1 report*) prior to the study being completed, is testimony to the effectiveness of this AI in achieving its aim to derive something meaningful from research that is helpful to practice.

7.1 Affirmative topic choice

This AI was comprised of four group workshops, with appreciative interviews being conducted between participants on a one-to-one basis between workshops one and two.

The first workshop started with an introduction to AI as a method. We then agreed some basic ground rules for the workshops as follows:

- Phones off/silent.
- Respect the opinions of others.
- Seek to understand and value perspectives where they differ from your own.
- Encourage participation.
- Focus on the positive and best.
- Acknowledge where the positives also by definition draw attention to difficulties.

These ground rules were designed to protect the vulnerability of participants sharing their experience of practice and their personal views (Malone 2003), while equally promoting engagement in the AI process to enhance the wholeness principle of seeking multiple perspectives (Whitney and Trosten-Bloom 2010).

The first stage of an AI is to determine the focus of the study, termed affirmative topic choice (Cooperrider and Whitney 2005). Embracing the spirit of collaboration the decision about the focus is based on what practice the participants want to see flourish rather than this being determined by the researcher before the study commences (Whitney and Trosten-Bloom 2010). This affirmative topic choice stage may be viewed as the foundation to the 4-D cycle of AI, a prologue where the scene is set for what is to come in the rest of the study. Carter (2006) identified that much AI research in the United Kingdom uses

external researchers to gather information, potentially diluting the collaborative benefits of AI. As an insider practitioner researcher I wanted to ensure that the collaborative nature of the approach was embraced, and giving participants the freedom to determine the focus of the study was the first way to ensure this happened. In this way there was a merging of researcher and participant, with everyone involved adopting both these roles.

The process of affirmative topic choice began with participants forming pairs (and one group of three) and conducting mini-interviews with each other. Each participant therefore experienced both asking and answering the mini-interview questions. Individuals then highlighted key messages from their interviews silently before discussing these in small groups (two pairs) then as a whole group to agree themes from which to build the affirmative topics. This iterative process of data analysis and theme development followed the broad principles of nominal group technique which advocates a period of silent reflection, small group introduction of ideas refined through larger group discussion, giving equal voice to participants who are experts in their field (Van de Ven and Delbecq 1974). The foundations in social constructionism, encompassed in the constructivist principle is evident from the beginning, with meaning being created through conversation (Whitney and Trosten-Bloom 2010). In this way the voice of each individual was reflected in the theme development, with participants voicing their own views based on their experience answering the questions, as well as their interpretation of the views of their paired partner. The rich discussions enabled participants to expand, refine, and synthesise their perspectives to create shared meanings.

The mini-interview questions were adapted to the AMHP context but based on a generic interview schedule developed by Whitney and Trosten-Bloom (2010). The questions were designed to give participants an experience of using positive questions, with conversation being central, creating inspiring stories about best practice (Whitney and Trosten-Bloom 2010). I chose to use this interview schedule because of its simplicity and direct adherence to the core principles of AI, in particular the positive focus and the invitation to consider future positive practice enhancement (see Box 1).

1. Tell me about a peak experience or high point in your professional life, a time when you felt really proud of your decision-making at the point of referral for a Mental Health Act assessment?
2. Without being humble, what do you most value about
   a. Yourself and the way you make decisions at the point of referral for a Mental Health Act assessment? What unique skills do you bring to this decision?
   b. Your team and the way decisions are made at the point of referral for a Mental Health Act assessment.
   c. AMHPs in general: what value do AMHPs bring to individuals and to society when making decisions about whether to proceed with a Mental Health Act assessment?
3. What core factors give life to AMHP decision-making at the point of referral for a Mental Health Act assessment when it is at its best?
4. If you had a magic wand and could have any three wishes granted to heighten the decision experience what would they be?

Box 1: Mini-interview questions

7.1.1 Themes

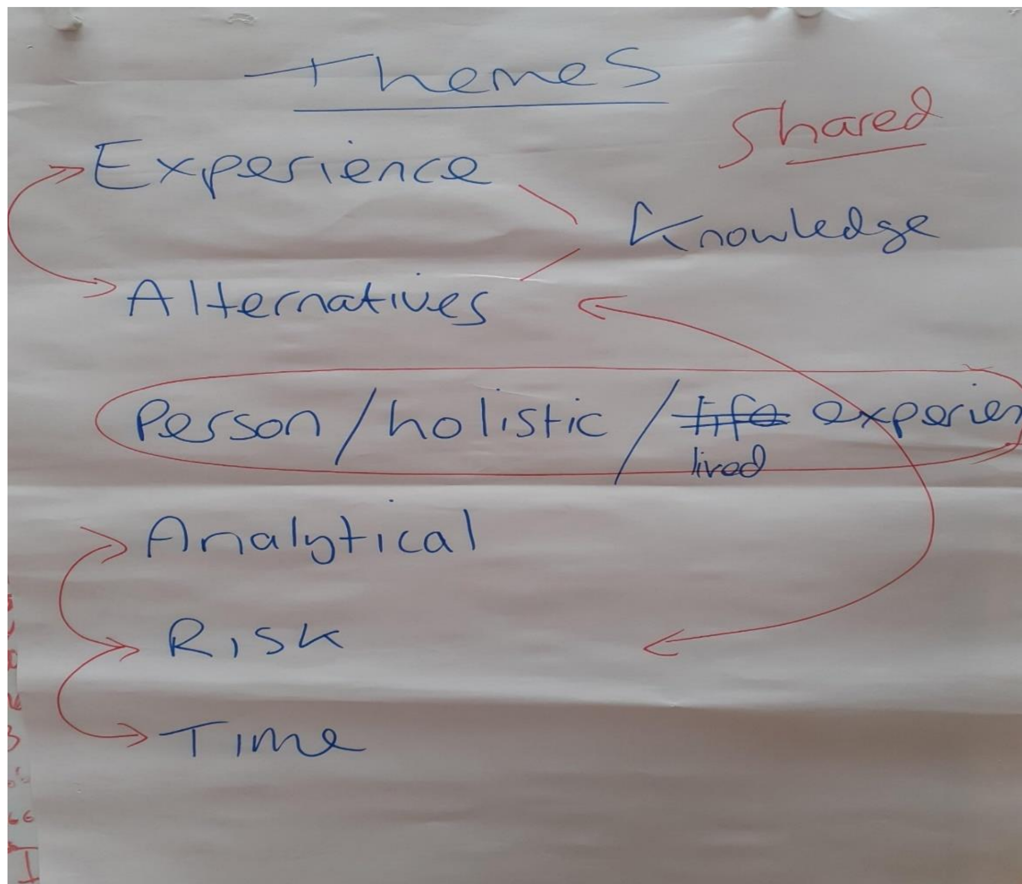

Figure 2: Agreed themes

An agreed set of seven themes were developed by participants in the workshop (see Figure 2). These themes formed the foundation to the affirmative topic development, which was the next stage of this AI, and which subsequently led into the AI 4-D cycle.

Before progressing to a description of the next stage of this AI I will first provide a summary of the themes and then more detail about how the themes were developed. The themes may be summarised by viewing the person and a holistic understanding of their lived experience as central. The term person-centred was not used in the summary of themes, but I offer it on reflection now as a coherent summary of the terms listed, based on participant accounts from the earlier discussions leading up to this point. The AMHP (implied) using their knowledge, experience, and awareness of alternatives to work collaboratively with the person referred. Being analytical, and issues of risk and time emerged, these concepts relating back to the AMHP and their knowledge and experience. In this way what looked like seven themes appeared to be grouped in three interconnected meta-themes. We recognised those themes during the workshops as can be seen by the interconnecting arrows (Figure 2), but we did not name them. Considering them subsequently the person is in the middle between the AMHP and risk, the AMHP drawing on their experience and knowledge to analyse risk and try to *buy time*. There was much discussion about the concept of time, with participants seeking a way to express how they perhaps manipulate time in some way to create opportunity.

What follows is a more detailed analysis of these themes enriched by the handwritten notes from the mini-interviews made by participants. Italics have been used in place of quotation marks given they represent the handwritten summary of one participant about the views presented verbally by another. In describing the evidence to support the themes I have considered it helpful to subdivide, or code each theme to provide a coherent structure. The development of these codes followed the same process of thematic analysis utilised in my literature review, derived from Braun and Clarke (2006), where I interpretively identified patterns in the data. These codes were not created during the workshops, rather I am reversing the process of data analysis conducted in the workshops to demonstrate my interpretation of how the overall themes emerged. This process highlighted the conflation of experience and knowledge within participant accounts, so seven themes were viewed as six in this analysis. The overall themes are represented in Figure 3.

Figure 3: Themes from the mini-interviews

This process of data analysis has only captured part of the picture, because while meanings were generated from the mini-interviews, they were further solidified through the discussions following those interviews, a dynamic process not recorded. A degree of further analysis to highlight parallels with my literature review and earlier cited theory will be integrated into this findings chapter to situate the findings in the context of this thesis as a whole. Participant quotes have been used only where required to build support for the themes rather than provide a full commentary. I have included a more detailed list of examples to support the mini-interview themes in appendix eight. Each theme will commence with a figure depicting the codes to provide a visual conceptualisation.

7.1.2 Detailed analysis of the mini-interviews

7.1.2.1 Experience and knowledge

Figure 4: Experience and knowledge theme with codes

7.1.2.1.1 Expertise

References to experience and knowledge in the mini-interviews echoed research surrounding expertise, with a sense of intangibility about concepts (Polanyi 1966; Dreyfus and Dreyfus 1984). This was exemplified by Sián who talked about a *wealth of experience*, framed as *expertise*, *not just applying the law,* extending into *personal and professional values*. Sián's reference to personal values offers a parallel to my literature review where morality is pervasive in ASW/AMHP detention decisions over and above technical judgements. Rhoda commented about drawing on her *experience of previous cases*, recognising *similarity even though different.* This perspective is consistent with literature surrounding expertise, where heuristics such as similarity or pattern recognition may be employed intuitively to note any previous experiences that may be of relevance to the current situation (Dreyfus and Dreyfus 1984). Expertise may be conceptualised by the integration of technical knowledge and experiential learning (Benner 2004), Sián and Rhoda acknowledging this but placing greater emphasis on the value of the latter.

7.1.2.1.2 Experience of risk

In the mini-interviews risk was seen as a key aspect of the decision to proceed with an assessment under the MHA 1983, much as with the ASW/AMHP detention decision (Sheppard 1990; Glover-Thomas 2011; Stone 2017). Risk was also directly linked with experience in the mini-interviews with Jake, Jean, Edie and Charlie. Jean for example spoke about *unique skills,* and *years of experience* in being able to *take information in* and *unpick risk quickly*, suggesting an increased ability to assess risk with experience.

Edie framed hospital admission as a *huge* decision in the context of discussing risk tolerance, which is consistent with the literature around ASW/AMHP detention decisions where the risk of admission is understood and forms part of the emotional aspect of the role (Morriss 2016a; Stone 2017; Vicary 2017).

Edie talked about *unique skills: being able to tolerate risk better than health colleagues*, a direct reference to the variability of risk thresholds, aligned with the literature in relation to ASW/AMHP detention decisions (Sheppard 1990; Peay 2003; Quirk et al. 2003; Glover-Thomas 2011; Stone 2017). While the literature does not support AMHPs from different professional groups having different thresholds of risk (Stone 2017), there is support for the impact of organisational culture on team level operational norms (Quirk et al. 2003). Jean and Edie both felt their approach to risk was unique to the AMHP role, suggesting that

professionals occupying other roles do not share the same skills. Their comments were offered in response to the question about what AMHPs in general have to offer, and imply risk assessment and risk tolerance are intrinsic qualities of the AMHP role.

Overall a range of references to experience were cited as influential yet lacking clear definition. As mentioned above this may relate to the nature of expertise. Familiarity with the role and each other may have led participants to feel it was unnecessary to explain in more detail about what they meant by experience (Morriss 2016b). This is likely to have been compounded by my insider status, equally unable to recognise the need to articulate meaning more overtly. Reflecting on these possibilities I am minded to recognise the vague references to experience as both an inability to articulate *and* a sense that to do so was unnecessary. We all unconditionally accepted that experience was relevant, without considering further why this might be the case. The dynamic nature of an AI, where data analysis occurs inside the research process rather than subsequent to it makes such oversights likely if not inevitable. Nevertheless it should be accepted that the strengths of a collaborative research process come at a cost.

7.1.2.1.3 Technical knowledge

Abbott (2018) found a lack of direct reference to the law in AMHP detention decisions, but practice firmly rooted in a legal context. Similarly in this study a technical knowledge of the law arose in only three of the mini-interviews, cited by Rhoda, Frank and Jean with comments such as *legal frameworks* (Rhoda and Frank) and *a good underpinning of law* (Jean). This may be because the legal aspects in this specific decision were not considered of primary relevance, or it may be that as with expertise (Dreyfus and Dreyfus 1984; Polanyi 1966) most participants weren't recognising its impact on their decision-making.

The notion of *specialisms* came up in group discussions, meaning knowledge and experience of particular issues or groups, such as children or dementia, or of services as an alternative to admission. Charlie's notes from the small group discussions incorporated the metaphor of *mapping the landscape* which was connected to a knowledge of the law and also a knowledge of services and resources. Charlie also used the metaphor of *navigation* to refer to contentious situations, introducing explicitly that these decisions are being made in a potentially adversarial atmosphere, echoing the findings from Abbott (2018) in relation to detention decisions.

Mapping and navigation as metaphors introduce notions of power and control in these decisions, situating the AMHP as in control of a process that could be oppressive or collaborative depending upon how it is managed. Buckland (2020) highlighted the AMHP as operating within a liminal space between people and services, but whereas both she and Kinney (2009) highlighted the disjunctive nature of the power to detain and the absence of power over resources, Charlie has presented this power in an appreciative light, mapping referring to considering alternative options to admission, and navigation referring to managing conflict rather than becoming paralysed by it. Hall (2017) highlighted the lack of power held by ASWs over alternatives to admission, subsequently conceptualised by Buckland (2020) as a disconnect between legal and available power. Reframing these issues in a positive light gives rise to optimism about the AMHP role in this context, perhaps in response to the nature of the methodology adopted in this research, but also suggestive that at the point of referral for an MHA assessment there is greater optimism about the way in which the AMHP may be able to influence the situation positively. The use of appreciative questions in the mini-interviews appears here to have generated a positive discussion about an aspect of practice that could equally be raised from a negative perspective. The positive principle of AI seeks to promote positive change from positive conversations (Whitney and Trosten-Bloom 2010), and this appears to be a good example of this principle being enacted.

7.1.2.1.4 Knowledge of the person

The literature about detention decisions supports the importance of knowledge of the person (Peay 2003; Quirk et al. 2003, Glover-Thomas 2011; Stone 2017). Knowledge of the person was cited by Sián, Edie and Jake in their mini-interviews, and was noted by Charlie in his notes from the small group discussions after the mini-interviews, with comments such as *experience of the client* (Edie) . In my literature review I have related this knowledge with morality, citing Whan (1986) who wrote about social work as moral engagement, and Chu et al. (2009) who conceptualised moral decisions as those created between the social worker and the service user. Stanford (2011) added risk constructs are created on a personal level by the social worker. I have anchored these concepts in my literature review under the theme of morality, with knowledge of the person reducing risk perceptions (Quirk et al. 2003; Glover-Thomas 2011; Stone 2017). The participant comments from the mini-interviews suggest the same applies to the decision to proceed with an MHA assessment. Sián gave her example of when she had been at her best as when

she wanted to ensure professionals who knew the person well actively contributed to the decision about whether to proceed with an MHA assessment in a situation where a *strategic* meeting was held without such professionals involved. Following from notions of power introduced above, the emphasis of power here is located closer to the individual referred. In my experience the relationship between the person referred and the service has broken down at the point an MHA assessment is being considered, echoed by (Abbott 2018). The reintroduction of the person into the process vicariously is a step toward involvement, and a preference for this knowledge over specialist knowledge humanises the decision, echoing the moral aspect of detention decisions highlighted in my literature review.

7.1.2.1.5 A breadth of knowledge

A broader less technical form of knowledge was advanced by Jean and Edie when describing the way they made decisions, echoing the notion of social work as art (England 1986). Jean's themes from Edie's mini-interview included a *broader picture*, a *breadth of knowledge* and a *different set of skills and knowledge*. There may be parallels to the social perspective AMHPs are required to bring to decisions (DoH 2015, chapter 14.52). Further, it may be relevant to acknowledge the context of these AI workshops, where AMHP colleagues were discussing their role with each other. Morriss (2016b) found her interviews with other AMHPs became a form of co-narration and shared understanding, something which seems equally relevant here with Edie and Jean. This supports social constructionism, where meaning is created through conversation (Whitney and Trosten-Bloom 2010).

7.1.2.1.6 Wider support

Quirk et al. (2003) and Gregor (2010) both found peer support was helpful to ASWs when making detention decisions, echoed in the mini-interviews by Sián and Rhoda when responding about the value of the team in relation to the decision at the point of referral for an MHA assessment. Wider support was situated in the context of experience and knowledge. Sián talked about drawing on the experience of others in the team as a form of support but also to help identify her own gaps in knowledge. Rhoda mentioned clarifying her views during these conversations with others, drawing on support and advice from colleagues. Social constructionism is evident here, with Sián and Rhoda creating a subjective reality through communication.

Sián went on to include *healthy disagreements* and using colleagues as a *sounding board*. Edie spoke about *canvassing views* and *getting all angles*, as well as *lively debate with colleagues,* suggesting differing opinions were welcomed. Another principle of AI is wholeness which seems relevant here, where the whole picture is formed through a synthesis of multiple stories (Whitney and Trosten Bloom 2010).

Sián linked peer support with it being *a lonely place as an AMHP*, an acknowledgement of the responsibility AMHPs carry as individuals given the independence of their decision (DoH 2015, chapter 14.52). This was repeated by Charlie, and Ro spoke about a *united front* and a *team approach* as increasing her confidence in her decision-making as an AMHP, adding this made her feel *safe and supported,* a sentiment echoed by John. This resonates with the value of team support discussed under the theme of accountability in my literature review regarding AMHP detention decisions, most clearly articulated by Gregor (2010) in whose study the ASW participants valued team support. Frank didn't mention team support in his response to the value of his team, rather he highlighted *lone working* as a constraint. Frank was an AMHP in an emergency duty service working out of hours where there was less team support available. Frank and Sián both made an explicit reference to something negative: Uncommon in the workshops, this is an example of the emergence of negative stories, still encouraged within AI in order to enhance criticality (MacCoy 2014), drawing attention to the shadow created by the best stories (Fitzgerald et al. 2010). Frank and Sián both named the shadow cast by the benefit of team support, recognising the impact when this is absent.

7.1.2.2 Alternatives

Figure 5: Alternatives theme with codes

7.1.2.2.1 Visiting the person referred as part of 'trying anything'

Alternatives were raised in respect of alternatives to detention, albeit there was a sense these alternatives should be explored prior to carrying out an MHA assessment. In their example about the best of their practice six participants (Charlie, John, Jake, Jean, Rhoda, and Ro) all spoke about visiting the person referred prior to making a decision about whether an assessment was necessary, and the examples offered conveyed a purpose of exploring alternatives to detention. This can be linked to the principle of least restriction (DoH 2015, chapter 1.1), specifically the consideration of less restrictive alternatives to detention in hospital. Thompson (1997) and Thompson (2003) provided case examples of ASWs unilaterally assessing people prior to involving doctors, and Quirk et al. (2003) referred to ASW's exploring alternatives prior to convening an MHA assessment. More recently in her opinion piece Rooke (2020) has advocated meeting the person prior to deciding about an assessment, although she has cited this in the context of practice under s 115 MHA 1983, which allows an AMHP to enter and inspect a premises where a person with a mental disorder is living and is believed to be neglected. None of these authors have overtly recognised the legitimacy of such an action under s 13(1) MHA 1983, the legal foundation of this study, yet from Thompson (1997) to this study there is a thread of

consistency that seeing the person, however conceptualised, is a valuable consideration for the AMHP prior to deciding about whether to involve doctors in an assessment process. This is a key finding because it validates the notion that AMHPs seek to conduct an assessment as part of considering the patient's case, but prior to the involvement of doctors in any assessment process.

Rhoda talked about the visit prior to deciding about assessment being about *problem solving*, and she gave examples of buying a heater, organising food and *trying anything*. She spoke about the AMHP having an awareness of other options and services and seeking *any other way*. In Charlie's example where other professionals had failed to gain access to the person he wrote a letter to them explaining the concerns and organising a visit the following day. He then went on to explore a wide range of factors including obtaining family views. Consultation with others, including family, is one of the AMHP duties (MHA 1983, s 13(1A(b)), and here Charlie was advocating establishing these views in advance of agreeing to an assessment. Charlie spoke of being *methodical* and *not rushing in*. Later in Charlie's notes about the themes from the mini-interviews he used the metaphor of a *set of brakes*, with a view to *establishing facts*, and *testing reality*. He noted it is *not just doing an assessment when asked*, and that *when you try everything else it is not a failure* [to go ahead and assess the person with doctors under the Mental Health Act]. He wanted to *try to do everything not to detain,* supported by Edie. Rooke (2020) similarly acknowledged an AMHP desire to prevent the need for an assessment, recognising the assessment itself as potentially distressing. From my literature review Kinney (2009) spoke about a sense of failure when he detained someone in the absence of alternative resources. Charlie and Edie's focus was on creating an opportunity to explore alternatives, rather than there being no alternatives. Jean didn't go into detail but her example was taking someone onto her caseload to explore alternatives and avoid admission. In this way she utilised her dual role as care manager and AMHP to find an alternative to detention. Again Rooke (2020) similarly highlighted the role of the AMHP in their wider context.

Jake described the organisation of a *joint visit* with a professional already involved in the referred person's community support as having *negotiated down* from a request for an MHA assessment. There is an implicit recognition here of the potentially damaging nature of an MHA assessment. There is also a parallel to Leah (2020) and her identification of the *mediator* role being one of the many hats worn by an AMHP, whereby the AMHP mediates across organisational boundaries to reach the best outcome for the person referred. Jake

went on to refer to exploring evidence for concerns about risk and *negotiating room for manoeuvre to avoid admission*. In these examples the visit to the person referred has enabled the AMHP to consider alternatives to an assessment under the Mental Health Act. Hall (2017) identified the ASW role of negotiator, both with the person referred and, in the context of Hall's (2017) study, the home treatment team. He highlighted how this negotiation role incorporated the ASW supporting the home treatment team to feel secure in an alternative plan (Hall 2017). There is an implicit acknowledgement from Jake and supported by Hall's (2017) study that agreement from wider services is an important aspect of negotiating alternatives to hospital admission.

7.1.2.2.2 Assessment as a last resort

Assessment as a last resort featured in the examples offered above to support visiting the person prior to an assessment, but in her example of attending a meeting rather than visiting the person Sián started from a position of thinking there's *no way this is a Mental Health Act assessment,* and feeling *there must be another way*. She spoke of trying to *pull apart why other options didn't work or wouldn't work*. She spoke about looking for *strengths, protective factors* and *positives*, and a desire to *get back to what works*. Sián started with seeking an alternative to assessment under the Mental Health Act, which explicitly moves any emphasis away from an MHA assessment. This aligns with the principle of least restriction (DoH 2015, chapter 1.1), and reflects the advocacy role evinced by Leah (2020) as one of the hybrid professional roles of the AMHP.

Frank talked about a *quick strategy meeting* where circumstances required him to make a decision about an assessment quickly. This appears to promote an element of shared decision-making with other professionals involved in the situation, perhaps aligned with seeking wider support as above. The inclusion of a strategy meeting promotes a pathway to assessment that seeks to build in opportunities to find alternative options.

7.1.2.3 Person-centred

There were several terms that emerged repeatedly through the mini-interviews, including *person-centred* (Sián), a *broader view* (Frank, John), a *wider picture* (Rhoda), a *global picture,* thinking *holistically* (Edie, Ro), and considering a *social perspective* (Charlie, Rhoda). One or more of these terms were evident in most mini-interviews in response to the question about the value of the AMHP in general. The following codes offer a way to break down this theme and provide rich detail (see Figure 6).

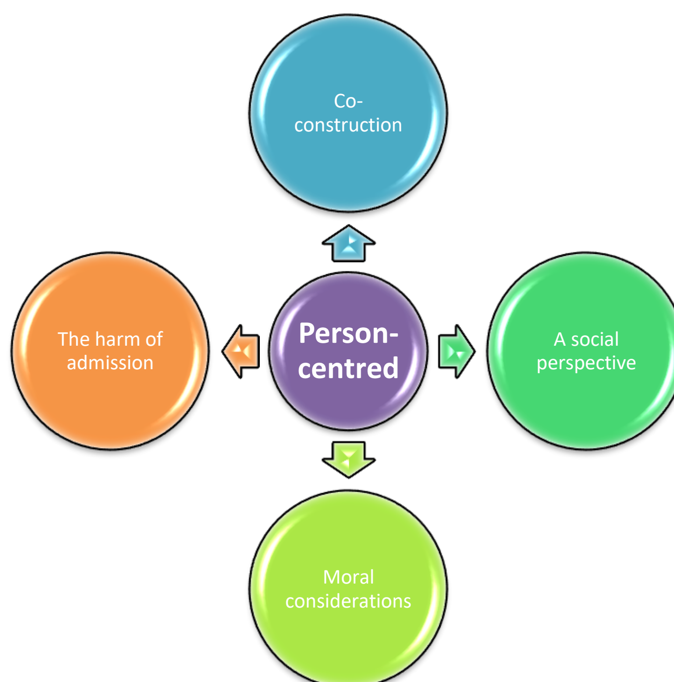

Figure 6: Person-centred theme with codes

7.1.2.3.1 Co-construction

In his study of AMHP detention decisions Stone (2017) recommended the co-construction of risk issues with service users, though this was not evident in the results from his study. Charlie and Rhoda made comments indicating a greater possibility of co-construction at the referral stage. Charlie talked about trying to involve the person and talk about the concerns. He said he wanted to understand and listen to people, promoting dignity and respect. He described being person-centred as *not just [about a] treatment plan and getting people to bend to [our] will*. This perspective concords with social constructionism, with reality here being created between the AMHP and the person referred. Rhoda mentioned *choice and capacity*, reflecting a similar desire to incorporate the person's wishes and feelings and extending this to consider their capacity to make decisions. This reflects the principles of the MCA 2005 which the MHA 1983 Code of Practice supports are relevant to MHA 1983 decisions (DoH 2015, chapter 14.12). This is an interesting point not least because capacity does not form part of the primary legislation for mental health detention. Advocates for what has been termed *Fusion* (Dawson and Szmukler 2006) seek a capacity-based law covering both physical and mental health interventions, and while the MHA 1983 review did not recommend this course of action it did incorporate a range of suggestions to include capacity into some decisions taken about detained people (DHSC

2018), though notably an assessment of capacity does not feature in the recommendations about initial detention criteria. Concerns about the reliability of capacity assessments in crisis situations were cited (DHSC 2018), echoing an acknowledgement of the same from Fusion advocates (Dawson and Szmukler 2006), though the latter was more open to further research to clarify this.

The emphasis of the fusion approach aligns with Rhoda and Charlie's expressed view above, with a focus not just on capacity but also choice (irrespective of capacity). Where a person is assessed as lacking decision-making capacity substitute decision-makers make decisions that are consistent with their "'subjective' best interests" (Szmukler et al. 2014, p.249). This is distinct from best interests because it is person-centred, but remains a substitute decision. Article 12 of the UNCRPD (2006) advocates for a subjective best interest approach, termed in their general comment as a "best interpretation of will and preferences" (2014, Paragraph 21), but rejecting the notion of substitute decisions in favour of supported decisions. Rhoda and Charlie's comments support this latter interpretation, promoting true co-construction. The absence of co-construction in detention decisions but the suggestion co-construction forms part of the decision at the point of referral for an MHA 1983 assessment is an important finding in this study.

7.1.2.3.2 A social perspective

The notion that AMHPs see past a person's diagnosis was prevalent, often mentioned after terms like *person-centred*. The role of the AMHP is to bring a social perspective to decisions (DoH 2015, chapter 14.52), and these statements support this aspect of the AMHP role. The literature on detention decisions was divided about the extent to which AMHPs achieved this in practice in relation to detention decisions, with some arguing a medical perspective dominated (Sheppard 1990; O'Hare at al. 2013; Buckland 2016) and some a social perspective (Hall 2017; Abbott 2018). Most consistently in answer to the question about what participants valued about AMHPs in general seven were explicit about a social perspective, with comments such as *what we're here for* (Charlie); *balance to medical model* (Edie); *think holistically, more about social issues* (Ro); *think about as a person* (Sián). The implication from all participant accounts in this study is that AMHPs consider themselves adopting a social perspective at the point of referral for an MHA assessment. This appears to be a resounding acknowledgement that at the referral stage there may be greater opportunities for AMHPs to achieve this key aspect of their role.

7.1.2.3.3 Moral considerations

Notions of right and wrong link strongly to morality (Whan 1986), a theme developed in my literature review. Frank talked about *the right thing to do*, words adopted by many ASWs and AMHPs in relation to detention decisions (Dwyer 2012; Buckland 2016; Morriss 2016a; Stone 2017). Jake referenced *dealing with a life,* suggesting an acknowledgement of the implications of the decision on the person referred, and again reflecting the moral considerations related to the decision to assess. Sián mentioned *seeing the person as a person*, acknowledging a personal connection, exemplified by Ro, John, and Jean who spoke about a *use of self,* and understood by Whan (1986) as the enactment of moral knowledge.

7.1.2.3.4 The harm of admission

In my literature review there was recognition about the harm of admission in detention decisions from some authors (Smith 2001; Kinney 2009; Morriss 2016a). In this study Edie spoke about seeing the situation as a whole, including the effects of detention on *employment, family, stigma, side-effects of medication.* Rhoda spoke about *doing no harm* and recognising *the harm of admission.* John talked about *impact* and *stigma*.

Jake mentioned the term *least restrictive* which is a core MHA principle (DoH 2015, chapter 1.1). The notion of least restriction implies restriction is undesirable and by extension may be seen as potentially harmful. Ro and Jean separated the MHA assessment from the act of detention, mentioning the *impact of a Mental Health Act assessment*, acknowledged by Grace (2015) as itself harmful.

7.1.2.4 Analytical

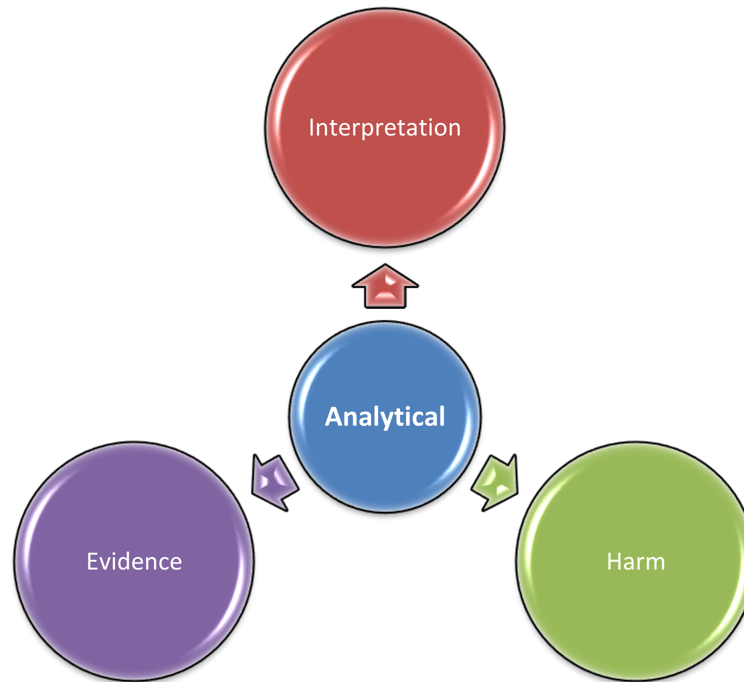

Figure 7: Analytical theme with codes

7.1.2.4.1 Interpretation

A critical view of the information provided by others typified participant views. There were similar inferences in my literature review on detention decisions, where Quirk (2007) found information from trusted sources was taken at face value, implying information from other sources was not, while Dwyer (2012) found ASWs assessed the quality of information from others. In his notes about themes Charlie talked about *establishing facts* and *judging how much information we need*, *testing reality* and considering *the agenda of others*. There is a contrast between notions about *facts and reality* which appear to relate to the information provided by others; and *analysis and interpretation* which seek to *test* what is presented. There is an acknowledgement in these statements that supports the world of multiple realities in social constructionism. In her mini-interview Edie talked about *getting all angles*, *disagreeing with opposing views* and *lively debate*. The ability to be critical is framed appreciatively here, a clear example that appreciation does not equate to an exclusive focus on positive issues.

7.1.2.4.2 Harm

The harm of admission has been discussed above, but there were further participant comments supporting harm as a key consideration in analysing information to inform decisions. Rhoda talked about *balancing the benefits and harm of hospital*, reversing the emphasis of risk in the community to the risk of admitting the person to hospital. Edie indirectly spoke about these risks, highlighting the *effects of admission and medication side effects*. Jean highlighted how this decision was not taken *lightly*, and Edie recognised it was a *huge decision.* As discussed earlier, acknowledging these risks appears to serve as a way in which participants adopted an advocacy role in their criticality about information provided by others when it comes to decisions about whether to carry out an MHA assessment, aligned with Leah (2020).

7.1.2.4.3 Evidence

Terms like *evidence* and *facts* were used by participants suggesting AMHPs seek to clarify a form of reality. Jake made reference to a professional *over-stating risk on little evidence*, something echoed by Charlie. Sián talked about being *analytical about risk* and an *openness* to finding *another way,* also resonated by Rhoda. Charlie mentioned *being clear of facts* supporting he didn't accept information at face value. John and Jean both described AMHPs as *analytical* while Jean also suggested risk assessment was based on *evidence.* Rhoda viewed herself as bringing *clarity* to decisions. She mentioned *having a good look at what's going on.* There is a suggestion in these comments that an objective reality exists below the surface, such as proposed in critical realism (Walsh and Evans 2014), and in the view of Porter (2007) where the preferred reality becomes the reality practitioners feel confident they can base their practice on. Equally the comments from participants support a shared sense of reality that could be explained through social constructionism, where broad agreement is reached through communication (Whitney and Trosten-Bloom 2010). These comments seem in contrast to the literature on AMHP detention decisions which place uncertainty as a central concern (Peay 2003; Skinner 2006; Buckland 2016). Here participants appear to be tackling uncertainty by analysing information and forming judgements based on a socially constructed sense of when someone might need an MHA assessment.

Edie however diluted the emphasis on evidence, suggesting decisions were about *facts, but other stuff*, conveying a sense that judgements are based on something less tangible. My

literature review on detention decisions highlighted the relevance of intuition (Kinney 2009; Glover-Thomas 2011; Dwyer 2012; Buckland 2016; Fistein et al. 2016; Stone 2017), and Edie's comments may be interpreted in this light.

7.1.2.5 Risk

Figure 8: Risk theme with codes

7.1.2.5.1 Thresholds of risk

There was broad agreement that AMHPs have a higher threshold of risk than other professionals. Charlie highlighted *people have over-inflated concerns,* supported by Edie and Jake. Charlie saw the AMHP role as providing a *counterbalance to a risk averse culture.* With these comments Charlie has suggested AMHPs are outside of this cultural influence, with an implication that risk aversion is greater among health colleagues, the *people* most likely to make referrals for MHA assessments. Edie identified being able to *tolerate risk* and so avoid getting *hooked in to a sense of urgency*. She talked about the *subjectiveness of risk* and being able to *support others with positive risk taking.* Notions of thresholds of risk are prevalent in the literature on MHA detention decisions (Sheppard 1990; Peay 2003 Quirk et al. 2003; Glover-Thomas 2011; Stone 2017), albeit the suggestion that AMHPs have a higher threshold of risk is new.

7.1.2.5.2 A balanced view

A considered approach to risk was evident from participant accounts. Jean spoke about being able to *unpick risk quickly*, echoed by Sián with the addition that AMHPs are *analytical about risks.* Rhoda spoke about *clarity* in terms of risk, while John and Ro spoke about *weighing up risk.* Jean explained she knows *what it's like to sit with risk in the community*, *being mindful of that*. She also noted about *positive risk taking.* Notions of risk may be less determinative from this perspective. John and Rhoda spoke about *risk averse referrals,* and Rhoda mentioned recognising the *harm of admission*. She went on to talk about *choice* and *unwise decisions* when considering risk, an indirect reference to the principles of the MCA 2005.

Sián highlighted the inverse emphasis of *looking for strengths and protective factors… positives,* reframing risk to the appreciative perspective. She went on to say AMHPs are person-centred and so don't focus on risk. She hoped in the future partner agencies would be *willing to work with risk.* These comments support that perceptions of risk inform decisions but are not determinative, rather risk is balanced with the potential harm caused by intervention. There is also a sense of sharing risk with people referred. The co-construction of risk has been suggested by Stone (2017) and Abbott (2018) as desirable in detention decisions, and Sián's comments apply this goal to the point of referral for an MHA assessment.

7.1.2.6 Time

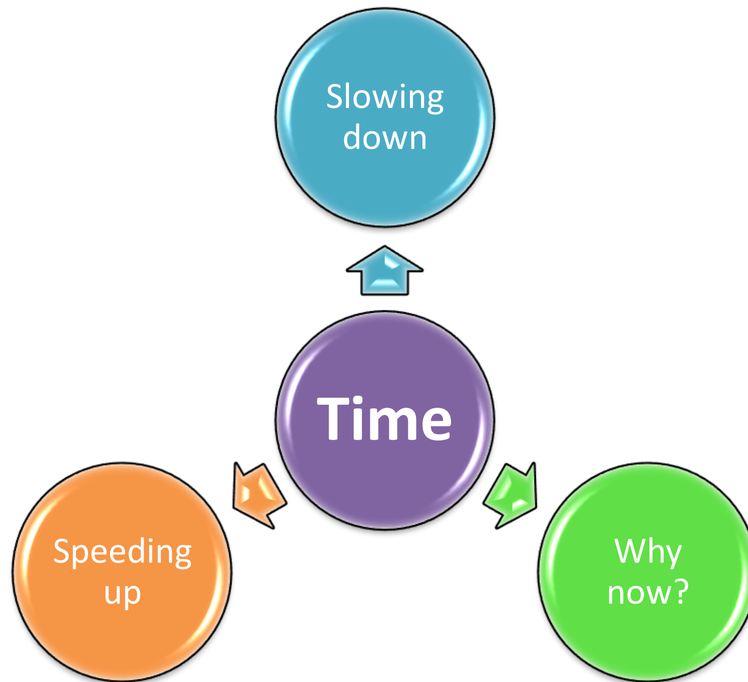

Figure 9: Time theme with codes

7.1.2.6.1 Slowing down

Participant comments support that AMHPs seek to create time to consider the situation and the available alternatives. In his mini-interview Charlie spoke of being *methodical* and *not rushing in* or being *reactive*, *slowing the pace,* comments supported by Jake and Rhoda. Later in Charlie's notes about the themes from the mini-interviews he used the metaphor of a *set of brakes*, *establishing facts*, and *testing reality*. The implication is that there is a pressure to make decisions quickly that the AMHP resists. Charlie felt it was important to *establish urgency and if there is time to try other things,* directly linking time with risk and alternatives, two of the dominant themes from my literature review on AMHP detention decisions.

Edie and Rhoda spoke about *not just react*[ing], and the need to *stop and take time, don't get hooked in to [a] sense of urgency, say I will think about this*. In her subsequent notes she recorded about the desire to *slow time* for *information gathering, processing and prioritising.*

7.1.2.6.2 Why now?

Participants questioned why a decision is required at all at this point in time? Jake queried *why now?* Similarly Rhoda asked *why today and not yesterday?* Sián talked about *trying to pull apart why other options didn't work and why they won't work now.* In considering risks she identified their chronicity, so if they remained unchanged over time then this should give time to explore them fully. For her time was about *de-escalation, testing alternatives* and *information gathering.* These points seem to use time considerations to question the necessity of an assessment.

7.1.2.6.3 Speeding up

There was recognition that while AMHPs may wish to slow things down to create opportunity to consider the situation and what alternatives there may be, sometimes this is not possible and decisions must be made quickly. Frank discussed a situation which he described as *time limited* but that this *focussed the mind.* He organised a *quick strategy meeting,* emphasising the limitations on available time. Jean also spoke of needing to *unpick risk quickly*, similarly referring to a desire to convene a *quick mini-conference.* John and Ro spoke about being *decisive* and *getting on with it.*

7.1.3 The contribution to knowledge from the mini-interviews

This concludes my summary of the evidence to support the themes generated in Figure 2 through the mini-interviews and subsequent discussions. These themes gave an insight into the way participants viewed the experience of interest in this study, namely the decision at the point of referral for an MHA assessment. The themes represented the first iteration of opinion on the matter, highlighting what participants wanted to develop through the AI. The focus on positives gave rise to a positive bias from the outset, counter to the predominant negative bias of traditional research approaches (Liebling et al. 1999; Carter 2006; Bellinger and Elliott 2011). This positive bias worked well to generate enthusiasm for the study, and where positive outcomes were being sought this approach did much to stimulate conversation toward enhancing practice aligned with the positive principle of AI (Whitney and Trosten-Bloom 2010).

An interesting reflection is that these mini-interviews gave rise to a significant amount of data relevant to the overall findings of the study. What was discussed in the mini-interviews was repeated throughout the study, with additional exploration and discussion solidifying these elements identified during this first stage. These mini-interviews began to

illuminate an experience much neglected in the literature, namely the AMHP decision at the point of referral for an MHA assessment. Already some key findings have been identified that generate new knowledge into this experience. These findings compared with my literature review into ASW/AMHP detention decisions have highlighted the importance of the decision at the point of referral for an MHA assessment, where aspects of the best of practice can be enhanced at this stage to a greater extent than later in the assessment process (see Figure 10). This new knowledge will be built upon and discussed later in this thesis.

Theme	Finding
Assessment	• AMHPs carry out a form of assessment at the referral stage
Meeting	• AMHPs want to see the person referred
Optimism	• The AMHP is optimistic at the referral stage
Co-construction	• This is more possible at the referral stage than later on
Social perspective	• There is greater opportunity to promote this at the referral stage
Clarity	• AMHPs are able to achieve greater clarity about risk at the referral stage
Risk	• AMHPs have a higher risk threshold
Time	• AMHPs seek to slow the process down, creating time to explore alternatives

Figure 10: New knowledge about the point of referral from the mini-interviews

7.1.4 Agreed affirmative topics

The next part of the AI process was to agree the affirmative topics based on these themes. Affirmative topics represent the focus of the study, so while the experience of the decision at the point of referral for an MHA assessment was pre-defined, the strategic course of the inquiry was to be set by the participants (Cooperrider and Whitney 2005). Affirmative topics are positively framed statements that stimulate conversation about a desired future (Whitney and Trosten-Bloom 2010). They are the basis of the AI interviews. The questions developed for the appreciative interview, based on the affirmative topics, focus the study on the elements of practice that participants want to see flourish. In this way it is clear how the themes influence the affirmative topics, which then influence the questions for the AI interviews, which further influence the data generated from those interviews (see Figure 11).

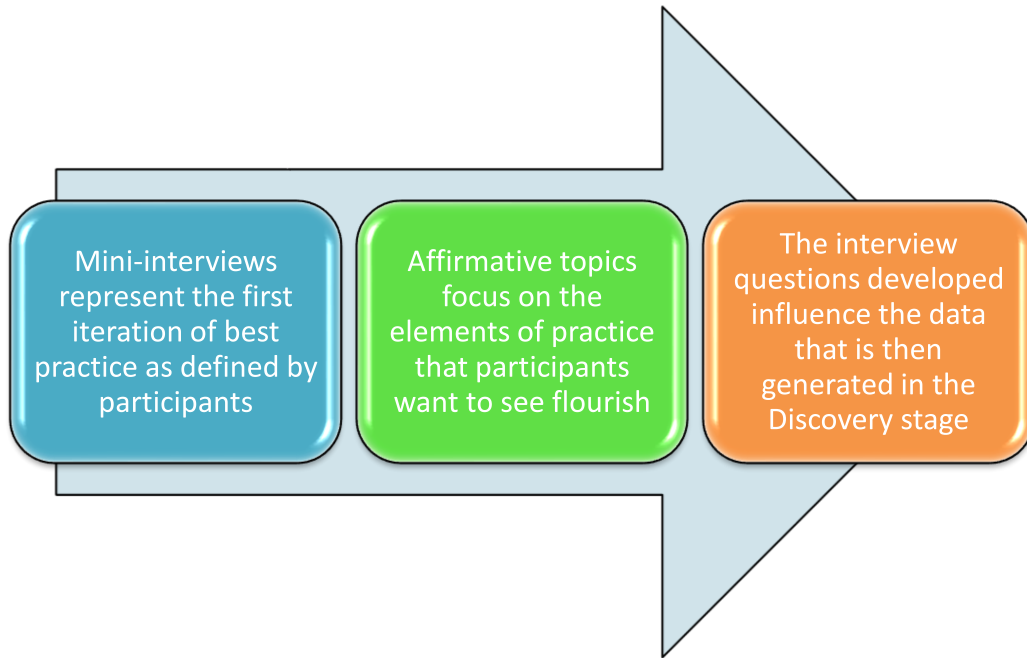

Figure 11: The process from mini-interviews to the 4-D cycle

Viewed like this it is unsurprising that the mini-interviews represent a rich foundation of data that is built upon later in the study. The methodology of AI focussed participant accounts on the best of their practice, and having identified the best, the rest of the study was about refining these ideas.

The process of developing the affirmative topics was discursive. After reminding participants about the elements of affirmative topics from Whitney and Trosten-Bloom (2010) we brainstormed ideas as a whole group, testing different ways of wording affirmative topics and considering combinations between themes. Once we decided to keep the affirmative topics short and simple the process became easier and we agreed the topics outlined in Figure 12.

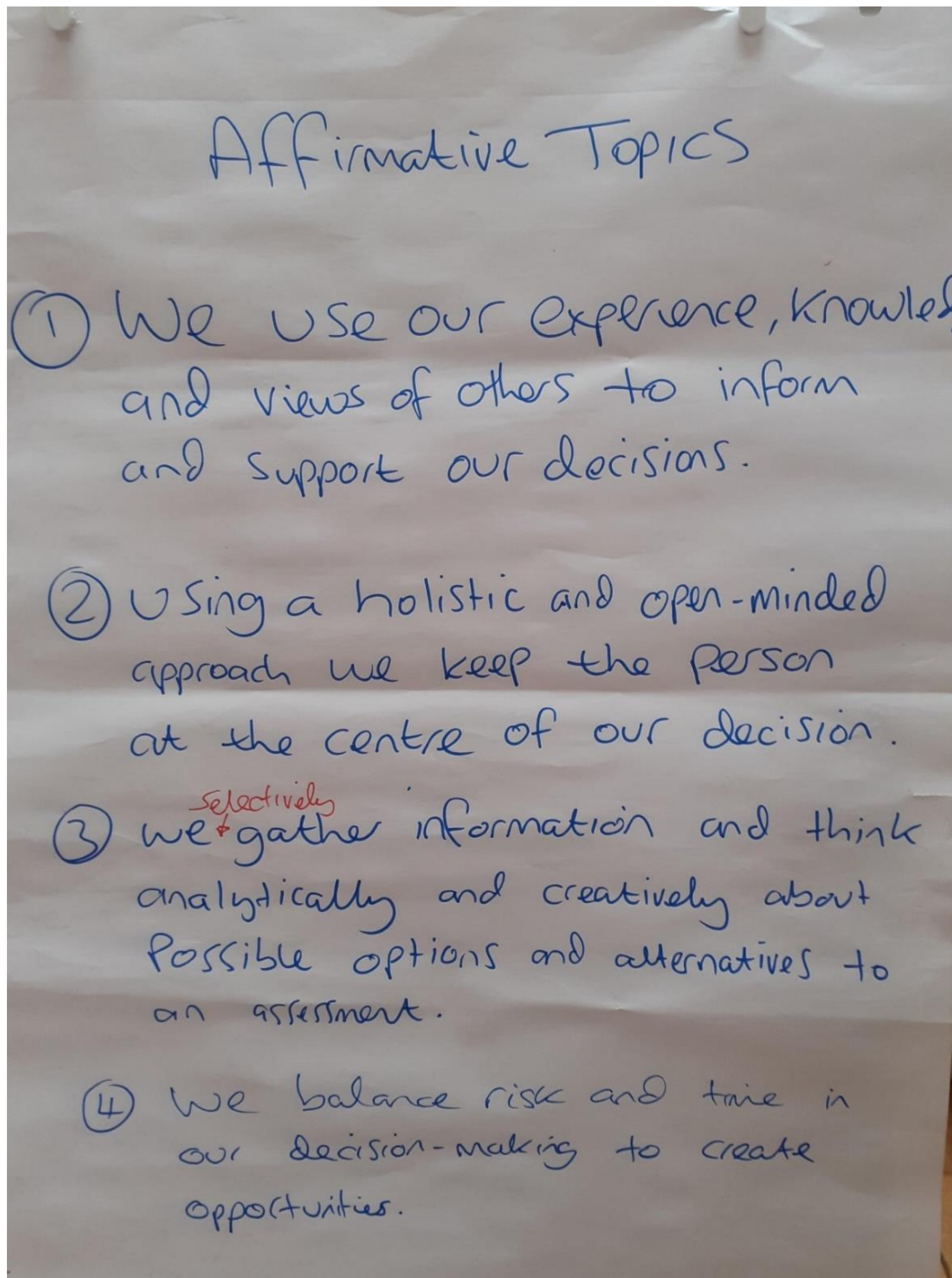

Figure 12: Affirmative topics

7.2 Discovery

7.2.1 Developing the appreciative interview protocol

Once the affirmative topics had been agreed the AI process moved into the 4-D cycle, starting with the discovery stage where the best of now is defined (Cooperrider and Whitney 2005) (see Figure 13).

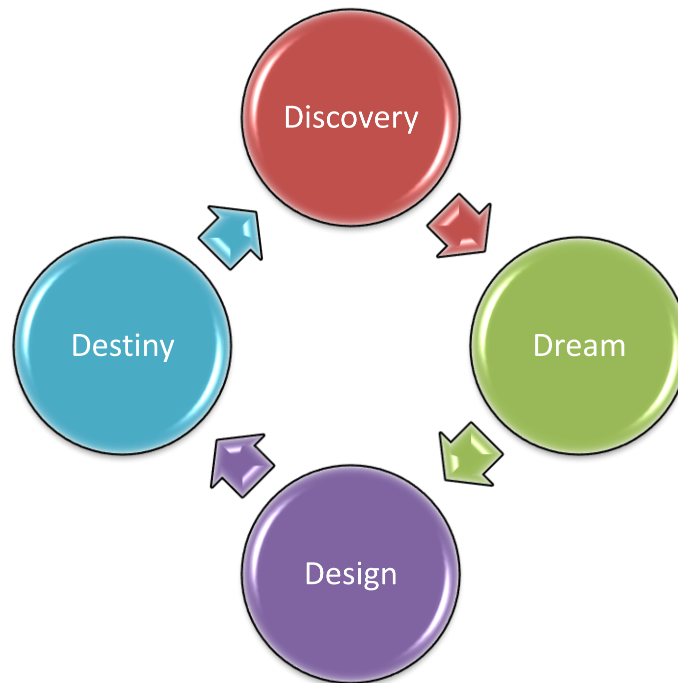

Figure 13: 4-D cycle

The first task in the discovery phase was to develop a set of appreciative interview questions based on the affirmative topics. Each affirmative topic was to have a set of two to four positively framed questions designed to generate positive stories based on the experience of those interviewed. Based on Whitney and Trosten-Bloom (2010) the intention was also to write a lead-in statement to set the scene for the question, but participants did not think this was necessary as the affirmative topics were considered self-explanatory. As with the affirmative topics participants favoured broad simple questions on the basis the question needed to stimulate a narrative. This approach is consistent with questions being “a list of opening gambits” (Liebling et al. 1999, p.79), and participants felt confident that based on the mini-interviews AMHPs would provide in-depth and lengthy responses. The questions were developed by the whole group as follows in Box 2.

1. We use our experience, knowledge and the views of others to inform and support our decisions.

a) How do you feel your experience and knowledge has helped you make decisions about whether to carry out a Mental Health Act assessment?

b) What difference does it make when you have support from others? Tell me about an example where this went well?

2. Using a holistic and open-minded approach we keep the person at the centre of our decision.

a) Can you give some positive examples of how you keep the person at the centre of the decision about whether to proceed with a Mental Health Act assessment?

b) What does being holistic look like when considering a Mental Health Act assessment?

c) What are the benefits of being open-minded when considering a Mental Health Act assessment?

3. We selectively gather information and think analytically and creatively about possible options and alternatives to an assessment under the Mental Health Act.

a) What creative alternatives to a Mental Health Act assessment might you use?

b) How do you select relevant information?

4. We balance risk and time in our decision-making to create opportunities.

a) In positive terms, how does risk influence your decisions about whether to proceed with a Mental Health Act assessment?

b) How can you make positive use of time in your decision-making about whether to proceed with a Mental Health Act assessment?

Box 2: Appreciative interview questions

The appreciative interviews were developed to be used among the participants at the workshops (interviewing each other) with an option to interview other AMHPs if the participants wanted to. The initial plan had been for the participant interviews to take place during the first workshop but the earlier activities had taken more time than expected. Participants agreed to interview each other before the second workshop to avoid the need to rush the earlier generation of affirmative topics. John, Frank and Jake all expressed a view that those present at the workshops knew much more about what we were trying to achieve, and involving others may not enhance the quality of data. As described earlier there was a socially constructed sense of ownership over the process and people appeared

to feel quite personally about what we were doing. There were concerns that others might not understand, and as such it was agreed that people outside the workshops would not be invited for interview.

7.2.2 Appreciative Interviews

Appreciative interviews were conducted between the first and second workshops, with paired participants interviewing each other. On the day before the second workshop, and coincidentally the day Jake and Frank had scheduled to interview each other, Jake was called away to a family emergency and was not going to be able to attend the workshop or participate in the interviews. Jake wrote his own responses to the questions and sent them to Frank for discussion in the second workshop, and I interviewed Frank in Jake's place.

7.2.3 Shared Meanings from appreciative interviews

We began the second workshop with some reflections about our experience of the AI so far, with participants valuing the positive focus and the chance to share stories, recognising our unique contribution, and validating our experiences. We then separated into two groups to discuss key messages from the appreciative interviews. This aspect of data analysis together with participants was one of the most compelling reasons for my decision to use this methodology: the meaning generated from the research would be defined by the participants themselves rather than by a dispassionate researcher. In this way I considered the socially constructed meanings generated would hold greater value for practitioners, helping to bridge the theory/practice divide, further supporting the link to pragmatism.

Each person presented the key messages from their interview and these were all listed, after which the whole group convened to agree shared meanings from these key messages (see Figure 14). This again replicated nominal group technique to enhance the quality of the data, promoting equal contribution and an iterative process of theory development (Van de Ven and Delbecq 1974).

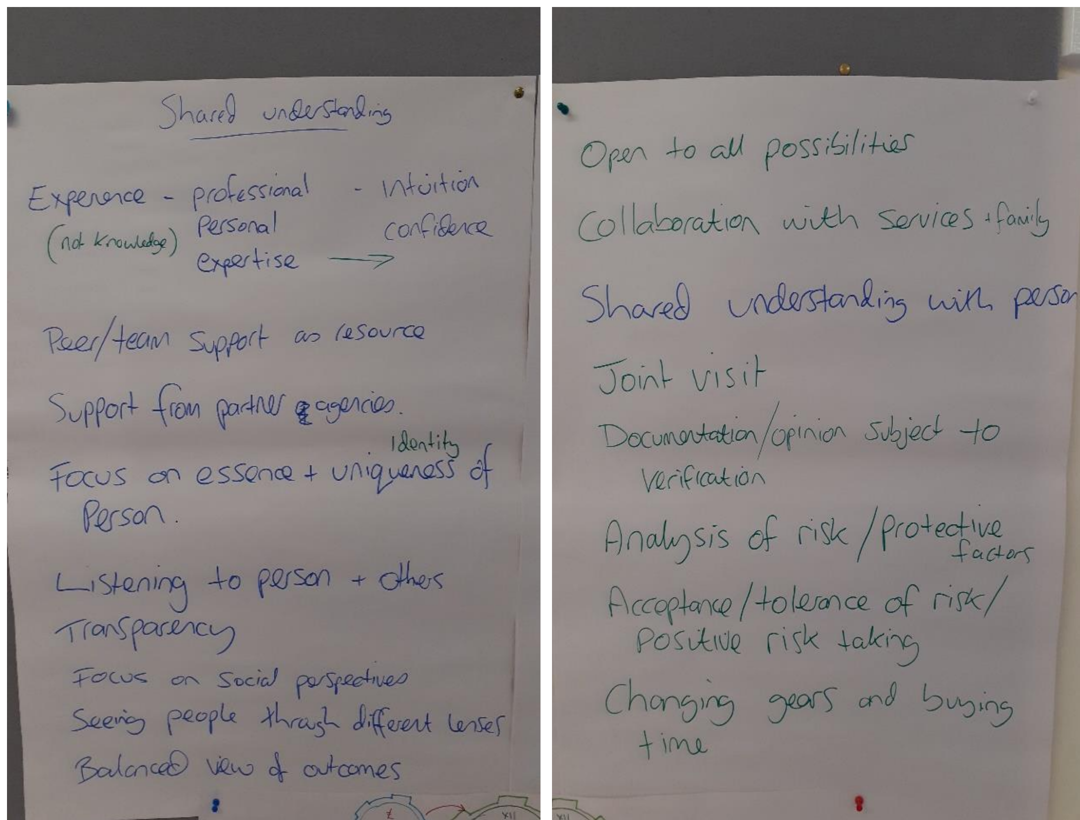

Figure 14: Shared meanings

In order to add depth to how these shared meanings were reached I will draw examples from the notes made from the appreciative interviews to illustrate each point. Italics have again been used in place of quotation marks given they represent the handwritten summary of one participant about the views presented verbally by another. In describing the evidence to support the themes I have considered it helpful to subdivide or code some of the themes to provide a coherent structure. Some themes did not require this subdivision where the data was more clearly focussed. The development of these codes followed the same process of thematic analysis utilised in my literature review, derived from Braun and Clarke (2006), where I interpretively identified patterns in the data. These codes were not created during the workshops, rather I reversed the process of data analysis conducted in the workshops to demonstrate how the overall themes emerged. To an extent this process only gained part of the picture because while meanings were generated from interviews they were further solidified in a socially constructed sense through the discussions following those interviews, a dynamic process not captured fully in the recorded data. Participant quotes have been used only where required to build support for the themes rather than provide a full commentary. I have included a more detailed list

of examples to support the interview themes in appendix nine. A degree of further analysis to highlight parallels with my literature review and earlier cited theory is integrated to situate the findings in the context of this thesis as a whole. I have represented the themes visually in Figure 15, and then each theme will be introduced with a visual representation of the codes.

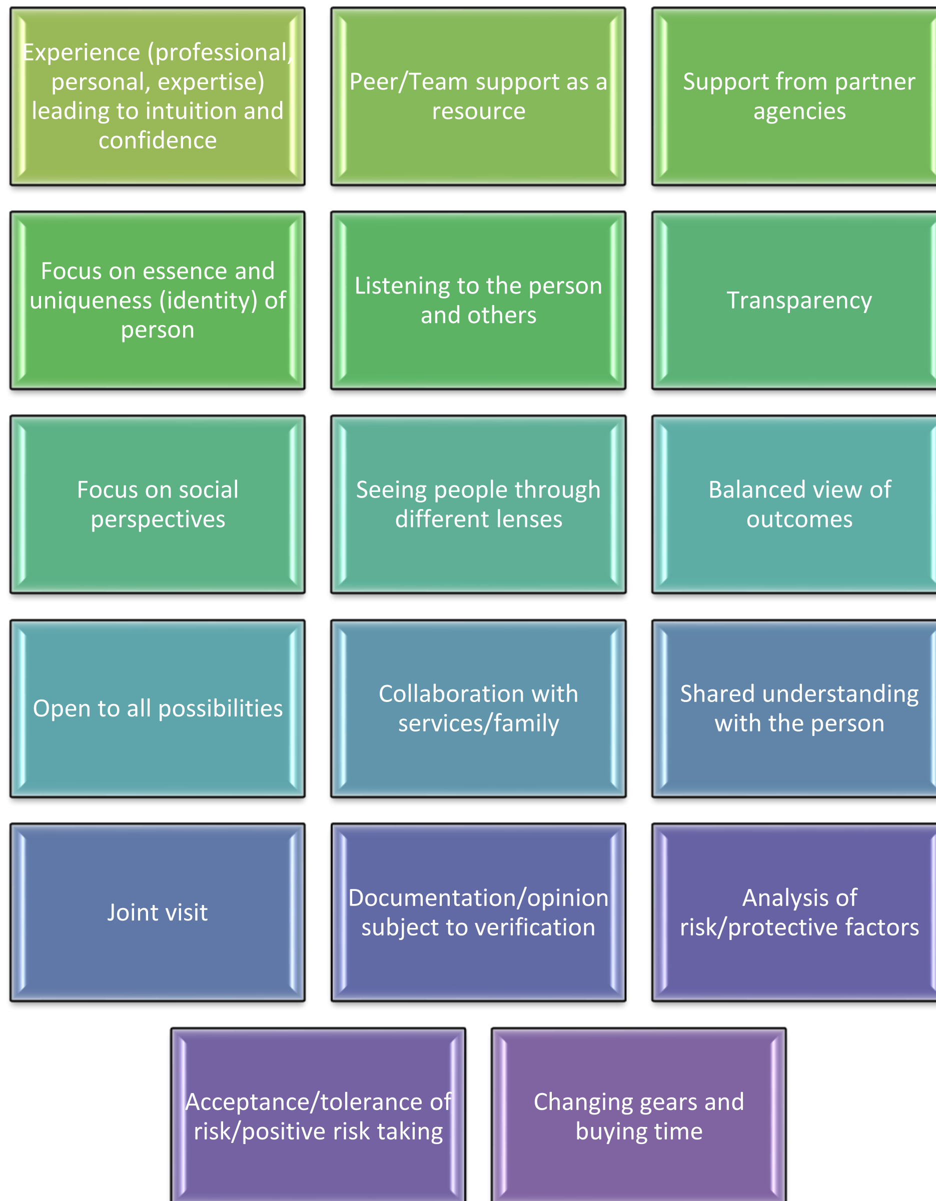

Figure 15: Themes from appreciative interviews

7.2.4 Detailed analysis of the appreciative interviews

7.2.4.1 Experience (professional, personal, expertise) leading to intuition and confidence

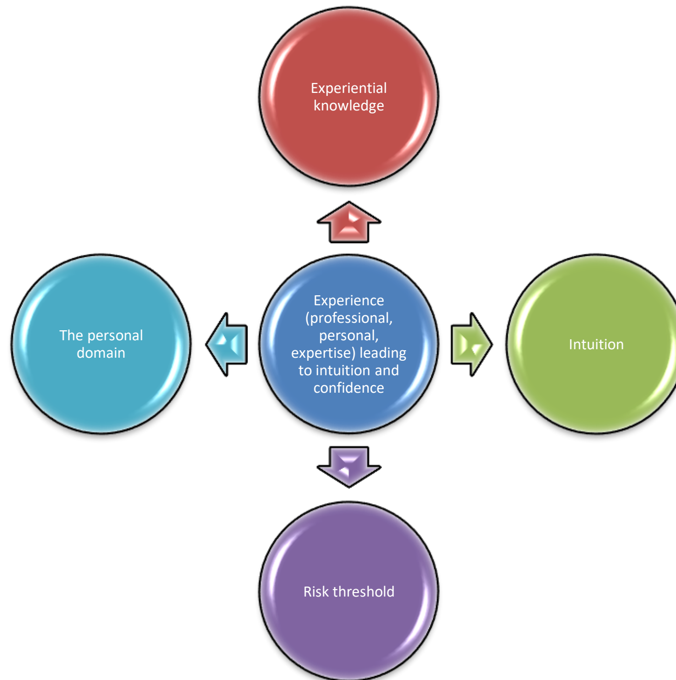

Figure 16: Experience (professional, personal, expertise) leading to intuition and confidence theme with codes

7.2.4.1.1 Experiential knowledge

Knowledge was explicitly excluded as a theme by the participants *(not knowledge)*, yet from the interviews it was evident experiential knowledge was relevant. Peay (2003) found ASW's wanted to get to know the person prior to making a decision about detention. Jake spoke about *knowledge of the person, those making the referral, and local resources.* Knowledge of the referrer has been previously identified as important in detention decisions (Quirk et al. 2003; Dwyer 2012), echoed here by Jake as influencing the decision at the point of referral. Edie listed knowledge of *mental disorder, treatments, the client and what they need to get better, doctors and staff and their knowledge of risk, resources.* Jake and Edie also spoke about knowledge of alternatives to detention in hospital (local resources) which was a dominant theme from my literature review on detention decisions, with Hall (2017) having highlighted the ASW role in exploring community provision, while other authors have focussed to a greater extent upon the absence of alternatives as

decisive (Haynes 1990; Quirk et al. 2003; Buckland 2016; Stone 2017; Glover-Thomas 2018).

7.2.4.1.2 Intuition

Literature surrounding tacit knowledge (Polanyi 1966) and expertise (Dreyfus and Dreyfus 1984) identifies an intangibility to these notions, evident in Jake's comment about *general intuition about the situation*. Intuition was equally referenced in the literature surrounding detention decisions (Kinney 2009; Glover-Thomas 2011; Dwyer 2012; Buckland 2016; Morriss 2016a; Stone 2017; Abbott 2018) leading to intuition as a sub-theme in my literature review. Jake's comments suggest a parallel between the detention decision and the decision at the point of referral for an MHA assessment. Such references to intuition were repeated by Charlie, John, Frank, and Jean, including from Frank who felt he had built up a *sense of realness of distress,* and Jean who highlighted that after *many years working in mental health you know when to do [an] MHA assessment.* These descriptions lack detail but support the notion that experts intuitively know but have forgotten the rules that inform their decisions (Dreyfus and Dreyfus 1984).

7.2.4.1.3 Risk threshold

Differing levels of risk tolerance in relation to detention decisions were first espoused by Sheppard (1990) and later supported by Peay (2003), Quirk et al. (2003), O'Hare et al. (2013), and Stone (2017). Ro spoke about having a *higher risk threshold,* and Edie concluded that she had become *more tolerant of risk with experience*. This was framed more as resilience to manage the impact of accountability, a dominant theme from my literature review on detention decisions. For Ro and Edie experience directly equated to higher risk tolerance, something not identified in the previous research into AMHP detention decisions. It is not clear whether Ro and Edie felt their risk tolerance was higher in all contexts or just the point of referral for an MHA assessment, but their responses combined with those in the mini-interviews from Charlie and Jake support more confidence about risk at the point of referral for an MHA assessment when compared to research into the ASW/AMHP detention decisions. The context of the decision at the point of referral is different from the detention decision because the AMHP acts alone rather than as part of an assessing team. A higher risk threshold is a key finding from this study given risk aversion within services is highlighted as a significant concern (DHSC 2018). If greater

tolerance of risk is achieved prior to an MHA assessment then the act of assessing arguably becomes intrinsically linked to risk aversion.

7.2.4.1.4 The personal domain

The bringing together of personal and professional domains was central to my suggestion of the role of morality in detention decisions from my literature review, espoused by Whan (1986) in relation to social work. Ro made reference to her personal experiences, specifically the *suicide of [a] close family member.* Rhoda equally mentioned *law embedded after course* and then *life experience… layered on top,* merging formal knowledge with personal and professional experience. Sián also mentioned she had *got to know a lot about people and law.* These comments recognise the value of legal knowledge but also the importance of the human context in which it is applied.

7.2.4.2 Peer/team support as a resource

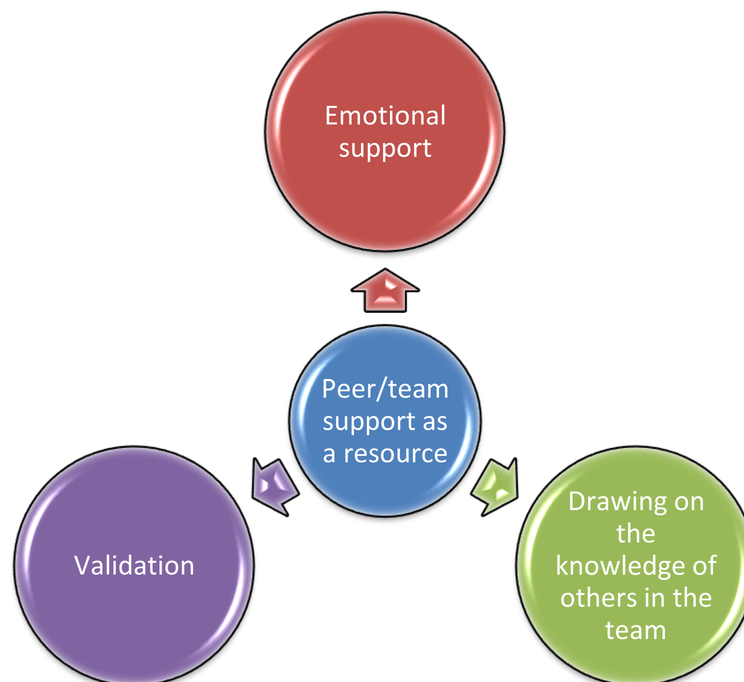

Figure 17: Peer/team support as a resource theme with codes

7.2.4.2.1 Emotional support

With respect to the referral for an MHA assessment Abbott (2018) identified “an adversarial atmosphere at the point of receiving the referral” (p.148), reflected in Jake’s experience of a *contentious* assessment in which he had a colleague with him for *moral support in an otherwise hostile environment.* Similar statements were advanced by John,

Ro, and Rhoda, adding that team support can help on an emotional level. John said that *just knowing that others will make themselves available is gratefully appreciated,* while Ro gave an example of emotional support in the face of a *bullying consultant [psychiatrist].*

7.2.4.2.2 Drawing on the knowledge of others in the team

Discussing situations with peers was suggested as helpful by Jake, Charlie, and Edie, the latter emphasising that *consulting others is helpful…[and] enriches the assessment and decision making.* Edie, Frank and Sián were explicit about the benefits of peer support in terms of drawing on the expertise of their colleagues. Quirk et al. (2003) found peer support reduced the likelihood of detention in ASW detention decisions, and Edie suggested drawing on specialist knowledge from peers allowed for *positive risk*, which is a term often used as shorthand for an increased tolerance of risk.

7.2.4.2.3 Validation

In the context of Abbott's (2018) recognition that the point of referral can be contentious, Jean said she used support from colleagues as a *way of checking my thoughts [are] not completely off beam, especially when being hounded to assess whilst knowing [it's] the wrong thing to do.* Jean reflected this support *gives me confidence to make particularly contentious and unpopular decisions.* There is an acknowledgement here that AMHP decision-making is fallible, and like most AMHPs she would have been taught about the *Bolam principle* regarding professional negligence, in which a court ruled a professional must act like another reasonable professional (*Bolam v Friern Hospital Management Committee* [1957]). This precedent was later updated in *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)* [2015] to focus on what a reasonable person would decide rather than deferring to other similarly qualified professionals. Nevertheless the *Bolam principle* is enduring here in the context of team support, further supporting a socially constructed reality of practice.

7.2.4.3 Support from partner agencies

Support from other agencies was about shared decision-making and collaboration, a theme discussed below. Charlie emphasised that where achieved it was then possible *to focus on the person and not team dynamics,* while Sián suggested *relationships with other teams [are] pivotal,* and Frank referred to *shared responsibility regarding risk.*

7.2.4.4 Focus on essence and uniqueness (identity) of person

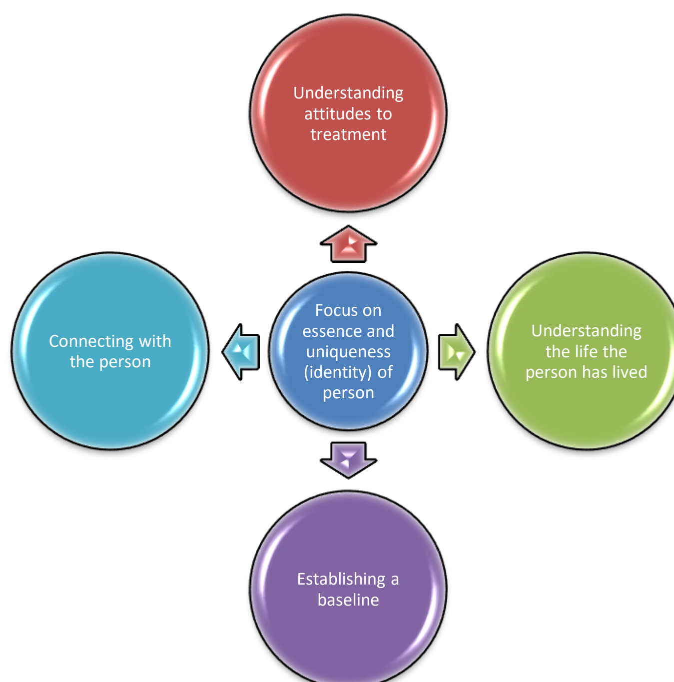

Figure 18: Focus on essence and uniqueness (identity) of person theme with codes

7.2.4.4.1 Understanding attitudes to treatment

The Human Rights Act (HRA) 1998 enshrined the European Convention on Human Rights (ECHR) 1950 into UK law. Article 3 of ECHR is concerned with the prohibition of torture, including "inhuman or degrading treatment" (Council of Europe 2013, p.7). Edie said it was important to establish the person's *wishes and views of admission. Their values come into that. Their way of life.* She went on to reference *HRA Article 3, degrading treatment, dignity, anti-depot, pinned down, injection is poison,* suggesting if a person has strong views against psychiatric treatment, perhaps preferring to live with symptoms, that she would *bear this in mind* as they might view the treatment as torture. Such comments are about core beliefs, a person's world view, and the importance of respecting this.

7.2.4.4.2 Understanding the life the person has lived

Jake, Charlie, Rhoda, and Sián made comments that emphasised a dominant medical narrative from those making referrals, and highlighted the social perspective of the AMHP, echoing Hall (2017) in relation to AMHP detention decisions. Rhoda's comments capture this point well: *see[ing] [the person referred] as [a] person, not just [a] demographic and [a] diagnosis,* echoed by Sián who emphasised wanting to know about them *as a person… with*

a life… strengths based not deficit based, aligned with social work values (SWE 2019). For Sián, understanding something about the person's past helped her to connect with them and therefore make a decision about their current needs. She recalled someone referred to her who *had been [a] film-maker [and] won awards for [their] work.* She said this information appeared *somewhat irrelevant but somehow help[ed].* This resonates with my literature review on detention decisions where a personal connection forms one aspect of morality which permeates decisions.

7.2.4.4.3 Establishing a baseline

Frank made comments to combine the person's world view with their current circumstances into the decision-making process. He asked *what is the person normally like?* He wanted to *understand them when they are well.* This point was implied in Sián's comments above but Frank made it more explicit that the person may be presenting differently to their usual self when they are referred for an MHA assessment. He later mentioned that *sometimes risk is part of who the person is,* suggesting that an understanding of the person and their lifestyle can allow AMHPs to share risk with them in times of crisis.

7.2.4.4.4 Connecting with the person

The value of a connection between the AMHP and the person referred is aligned with the morality theme in my literature review about detention decisions, echoing the importance of knowing the person prior to making such decisions (Peay 2003; Quirk 2003; Glover-Thomas 2011; Stone 2017). Jean made reference to a referral for an MHA assessment whereby she *looked at [the] information and took [the person] onto [her] caseload*. She identified that for the person referred with dementia *routine and familiarity [were] important.* Jean was able to use her knowledge of dementia to inform her understanding of the person referred. Ro made an indirect reference to this when she spoke about *when I know [the] client so well that I know admission would not benefit [them].*

7.2.4.5 Listening to person and others

Figure 19: Listening to person and others theme with codes

7.2.4.5.1 Establishing current wishes

Jake, Charlie, Edie, Frank, Ro, Rhoda, Sián, and John accentuated how decisions about admission should be shared with the person and their family in a spirit of collaboration, aligned with future aspirations of some authors in relation to AMHP detention decisions (Stone 2017; Abbott 2018). Charlie for example asked *what concerns the person or the family…. Ask the person what's the problem for them?* While Frank emphasised *people are experts in themselves,* and Sián wanted to *unpick what is going on with that person, why [they don't] want to engage, what does it mean to them.* The achievement of a collaborative approach, a social construction between the AMHP and the person referred, at the point of referral for an MHA assessment is a key finding in this study, particularly where collaboration was only aspirational in the literature about detention decisions (Stone 2017; Abbott 2018).

7.2.4.5.2 Establishing past wishes

There was an acknowledgement that the point the person is referred for an MHA assessment may not be the best time to ascertain their wishes and feelings directly, but that family and other professionals may be able to provide information to help inform the

decision. These points adhere to the principle of best interest decision-making enshrined in the MCA 2005, which while not directly relevant to the MHA 1983 are relevant within the statutory guidance (DoH 2015, chapter 13.25). Charlie made reference to people who lack capacity to make decisions about treatment, suggesting AMHPs ascertain *past attitude to treatment*, going on to highlight AMHPs *can learn from family about this.* Frank said he will *speak to people who know the person* in order to *understand them when they are well.* These sentiments were echoed similarly by Sián, Edie, Frank, and Ro.

7.2.4.6 Transparency

Transparency was mentioned by five participants in this study, with an emphasis on both transparency about the concerns but also transparency about the possible outcomes, and these issues were presented as one entity. This is an interesting insight into AMHP practice because it adheres to the principles of empowerment and involvement, and respect and dignity (DoH 2015, chapter 1.1), yet potentially diverges from later advice in the same Code of Practice which suggests making the person aware of the prospect of detention would invalidate any subsequent consent to voluntary admission (DoH 2015, chapter 14.17). I have raised this contradiction earlier in this thesis, and cited there an opinion advanced that a threat may be distinguished from an offer through transparency and a moral baseline, specifically that a person would be no worse off if they accepted your offer (Szmukler 2018). Jake for example mentioned *looking at different paths [and] scenario's with [people referred].* This suggests discussing *with* people and so sharing information about *scenario's*, which might include admission to hospital or ways this might be avoided, including alternatives to admission or at least alternatives to detention. This was advanced as a transparent discussion about possibilities rather than a threat. Charlie also talked about *sharing the concern and possibilities with the service user,* echoing Jake's sentiments but adding more clearly an emphasis about *concern.* He mentioned *transparency* and went on to say AMHPs *properly explore [the] option of people coming into hospital and allow them to make a decision.* He highlighted *don't say if you don't mean,* stressing a need to provide accurate information, respecting a moral baseline and therefore constituting a discussion in the realms of an offer rather than a threat (Szmukler 2018). Edie similarly mentioned *being transparent with the person explaining the concerns of the service,* highlighting that outcomes are not based solely on the person's choice, but that people within the mental health service will hold views about what should happen next that needs to be understood.

Sián suggested from her experience it is *interesting to compare to child protection services, [where professionals] always have to explain [the] consequences to [the] person and have frank conversations.* She emphasised a *parallel to [the] Mental Capacity Act also,* and how under the *Mental Health Act [it] is too easy to deprive people of [their] liberty without due process.* The MCA 2005 states that to assess a person's capacity to make a decision they must be provided with information relevant to it (MCA 2005, s 3(1)(a)), but no parallel duty is enshrined in the MHA 1983. Consequently Sián reflected that *sometimes people are taken unawares [about] concerns* and *this is worrying.* She spoke about using a joint visit as a way to *highlight concerns to people,* reflecting often *people [are] not given current information to make [a] choice.* For Sián a joint visit goes hand in hand with transparency and can *facilitate home treatment and social care involvement,* including *exploring what the barriers are to engagement* and often that *people worry talking about concerns will increase risks,* suggesting this is a misplaced belief.

This notion of transparency is another example within this AI where the shadow has become more prominent than the appreciative stance (Fitzgerald et al. 2010). Yet the desire to overtly discuss concerns and potential consequences with people is a way of turning toward problems, seeking ways of aligning a change process to address them through positive dreams rather than dwelling on the negativity (Bushe 2010), thus achieving criticality.

7.2.4.7 Focus on social perspectives

One of the key aspects to the AMHP role is to bring a social perspective to decisions about detention (DoH 2015, chapter 14.52). Overall a focus on social perspectives in this study was about understanding the person, their life and their current situation, and then exploring how social interventions might avoid the need for admission. The importance of this social focus is evidenced by seven of the nine participants raising such issues. My literature review into AMHP detention decisions highlighted a disparity in the literature about the extent to which AMHPs adopted a social perspective, with some authors suggesting a medical perspective dominated (Sheppard 1990; O'Hare at al. 2013; Buckland 2016), while others found a social perspective was adopted (Peay 2003; Hall 2017; Abbott 2018).

Jake didn't explicitly mention social perspectives, but he did refer to decisions being *not just looking at the criteria, risk etc… not just the medical model. Looking at context,*

including their *support network.* He said he sought to use the person's *own network to support* and therefore *avoid admission.* Jake made reference to situations where *admission might be more harmful,* and Edie echoed this, considering the *effect of admission. What would that do to them?* This perspective acknowledges that when enforced, admission and treatment is not benevolent.

Charlie mentioned *social stress factors we might be able to affect and avert the need for assessment.* He rejected a purely medical model, noting *yes [they] might have a diagnosis and are not taking medication, but is there anything else we can do to support?* Equally Frank acknowledged there are *lots of injustices in society,* and the importance of *recognising [the] impact of these issues*. Edie raised the need to explore the *whole current life of the person*, including *family situation, social supporters, employment, age and physical disabilities, cultural differences.* Sián suggested decisions would be *individual to the person [and that] what might be relevant to one [person] might not be [relevant] to another.*

Rhoda pointed out that *psychiatry [is] new, people would have always had illness but society [has] changed [its] views regarding mental disorder.* She mentioned someone with *fixed delusions [about] God talking but [*the person was*] happy so no need to treat.* She highlighted the importance of *social issues, environmental issues, financial issues, Maslow's hierarchy of needs: [the] basics need to be right.* In these comments she highlighted a social understanding of mental distress.

7.2.4.8 Seeing people through different lenses

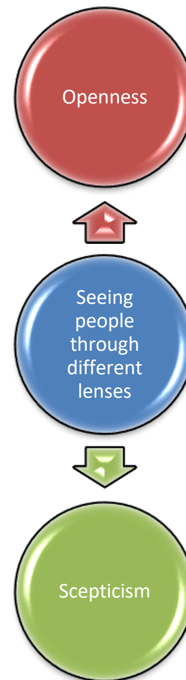

Figure 20: Seeing people through different lenses theme with codes

7.2.4.8.1 Openness

There was a desire for openness which echoes the wholeness principle of AI, where the whole is a synthesis of multiple stories (Whitney and Trosten-Bloom 2010). Frank explicitly referred to *look[ing] at individual[s] through different lenses; medical, psychosocial, psychodynamic.* Jake made reference to an *MDT [multi-disciplinary team] approach to solve issues,* while Sián mentioned being *open to new/different information,* which she felt *encourages you to explore detail.* She reflected that *sometimes one piece of information can be definitive / changes [the] situation on its head.* This openness indicates a desire to incorporate multiple stories before reaching a conclusion, though is more about information than incorporating different perspectives. Rhoda's focus was on being *holistic* and avoiding *one person's agenda.*

7.2.4.8.2 Scepticism

There was a bias toward avoiding an MHA assessment from Frank and Charlie, consistent with the principle of least restriction (DoH 2015, chapter 1.1). Frank highlighted there was *often a mismatch in person to on paper [in that things are] not as bad as [they] seem on paper,* while Charlie said the *starting point is scepticism, critical of the request, surely there*

must be something else that can be done, and that *other's views can be distorted,* but ultimately being open to detention as *the last resort on the list.*

7.2.4.9 Balanced view of outcomes

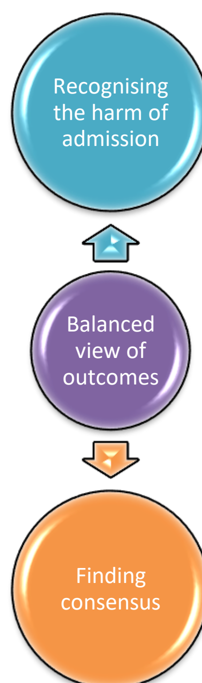

Figure 21: Balanced view of outcomes theme with codes

7.2.4.9.1 Recognising the harm of admission

This theme was focussed on providing a balance to a prevailing pressure toward detention from those making the referral, recognising the potential harm of assessment, admission, or treatment. Jake identified *a situation where the risks are moderate but [the person] would hate being detained and admission might be more harmful.* The emphasis here is on an intrinsic negative, perhaps on the face of it a departure from the appreciative stance desired from an AI. Yet the negative identification of risks rather than strengths represents the starting point at referral. The AMHP intervention here may be to balance that harm against another harm, namely admission to hospital, in turn undermining the rationale for detention. This ability to balance harms is a strength and appreciation of this is arguably consistent with AI. Equally Charlie acknowledged considering *if treatment is worse than letting be.* Edie referred to the same, the *effect of admission. What would that do to them? Distress to the person. Distress to carers.* Equally she referred to the *effects on close people and what they would say – can they handle it?* Edie's comments suggest understanding both the potential harm of admission to the person and the potential harm of not

admitting the person on the family or support networks. She talked about the *risk of admission and detention and treatment in hospital.* She reflected that often *the distress of the person is overlooked and not seen as a risk*, suggesting this is something AMHPs consider. This recognition of the harm of admission may relate to the higher tolerance for risk identified earlier, with AMHPs balancing risks rather than approaching risk one dimensionally.

John highlighted *the impact this request could or would have for the patient.* Frank also mentioned *acknowledging [the] implications of [an] assessment*, going on to give an example where he didn't assess but completed a *joint visit with the crisis team* and *gain[ed] agreement for [a] more stable pathway*, suggesting that the agreement for an alternative to admission was achieved by avoiding carrying out an MHA assessment, and inferring that this may not have been achieved if an assessment had taken place. This appears to recognise the harm of the assessment itself where a more collaborative approach was made possible by a less coercive intervention. In a similar vein Jean asked *will we escalate risk by such [a] heavy handed intervention?* Frank additionally made reference to *when admission just offers containment but doesn't improve [the] situation,* reflecting the purpose principle in statutory guidance (DoH 2015, chapter 1.1). Some authors from my literature review into AMHP detention decisions also highlighted the harm of admission (Smith 2001; Kinney 2009; Morriss 2016a), something I interpreted as a moral factor.

7.2.4.9.2 Finding consensus

There was a desire from Rhoda and Sián to develop a shared understanding with the person referred, with Rhoda acknowledging the importance of understanding the person's *views on meds [medication],* including a recognition of the *impact of meds, side effects.* She emphasised *trying not to impose.* For Sián it was important to adopt a *strengths-based perspective, look[ing] for protective factors to balance risk*. This is perhaps the most appreciative stance adopted under this theme, though Ro reflected that *at times an MHA assessment can draw a line and needn't be unpleasant*. The discussions during the workshop together with my own practice experience provide context to this statement. When a person is referred for an MHA assessment sometimes there can be differences of opinions between the AMHP service and other teams, with discussions taking place frequently over several days or even weeks. The notion of *draw[ing] a line* is a phrase frequently used where these disagreements remain unresolved. Sometimes AMHPs will agree to an assessment to share the decision about detention with two doctors. The

tension of resistance can be released by agreeing to an assessment even when you are unconvinced that detention will be necessary. Dwyer (2012) for example commented that once a decision has been made to carry out an assessment and the AMHP leaves the office it's "a relief to be in the car and on the way to resolving the situation" (p.343). The assessment itself is not detention, and an assessment to share a decision not to detain is a resolution sometimes sought when disagreements between teams remain unresolved. I have advanced my view earlier in this thesis about the potential harm of the assessment, and the risk of an unnecessary detention if this approach is adopted, supported by some authors (Peay 2003; Matthews 2015; Buckland 2016), but Ro has offered a counter-perspective important for an appreciation of the whole story (Whitney and Trosten-Bloom 2010). Then Ro has said the assessment *needn't be unpleasant,* highlighting the ability of the AMHP to create an atmosphere of dignity and respect even in the otherwise potentially oppressive situation of an MHA assessment. Indeed, Dwyer (2012) again highlighted

> "Empathy and a genuineness of response are crucial for humanising what is a situation of control" (p.366-347).

7.2.4.10 Open to all possibilities

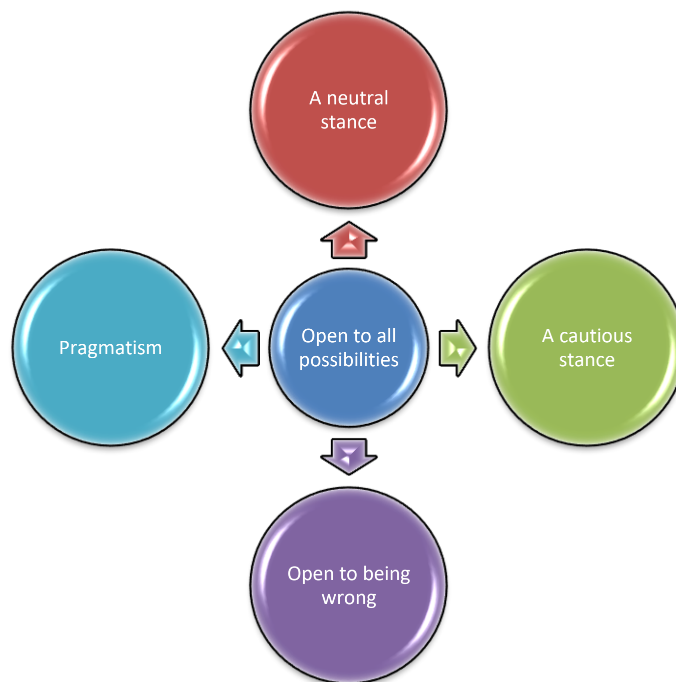

Figure 22: Open to all possibilities theme with codes

7.2.4.10.1 A neutral stance

Sián, Rhoda, Ro, and John suggested they strive to achieve an analytical and unbiased perspective, with comments such as *a blank sheet* (Rhoda) and *not being attached to an outcome* (Ro). These comments are consistent with the wholeness principle of AI (Whitney and Trosten-Bloom 2010), seeking to include a range of perspectives.

7.2.4.10.2 A cautious stance

Jean and Charlie however expressed caution in relation to the referral information, which may be viewed as counter to the negative focus on problems and risks at the point of referral, so while not strictly appreciative such a stance does encourage a more positive focus. Jean for example raised the possibility for the situation to be *over-egged*, while Charlie said he would start *from the point that surely there must be something else that can be done.*

7.2.4.10.3 Open to being wrong

Despite the influence of bias Edie and Frank emphasised their openness to being wrong, epitomised by Frank who was aware of a *sense of [my] own prejudices, biases, intolerances. Knowing [I am] not always right [and] not fall[ing] into [the] trap of [thinking I have] seen this before. Things are never the same*.

7.2.4.10.4 Pragmatism

A pragmatic approach was advanced by Frank and Jake which served to shift the emphasis to an appreciative stance consistent with the positive principle of AI, where a reframing to the positive promotes positive change (Whitney and Trosten-Bloom 2010). Frank spoke about taking a *positive approach [to] what works [and] what doesn't*, while Jake mentioned *more creative work* in the context of being open-minded. Frank gave the example of *when admission just offers containment but doesn't improve [the person's] situation,* so a practical focus on what works or doesn't work rather than attributing inherent qualities to one outcome or another.

7.2.4.11 Collaboration with services/family

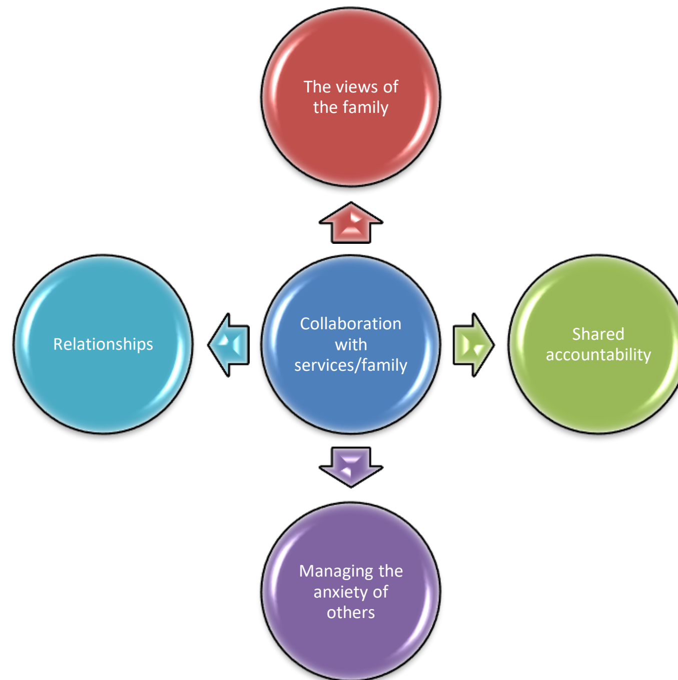

Figure 23: Collaboration with services/family theme with codes

7.2.4.11.1 The views of the family

Jake, Edie, Rhoda, and Charlie spoke about seeking the views of the family, for example *involving wider family,* the *effects on close people and what they would say* (Edie) and *contacting family [to see if] they can offer solutions* (Charlie), so considering the family as a potential resource to avoid an MHA assessment.

7.2.4.11.2 Shared accountability

There was a greater emphasis in the appreciative interview notes on collaboration with other services rather than the family. Frank spoke about developing *shared responsibility regarding risk* with consultant psychiatrists, seeking to *agree [an] approach to [the] referral*. The emphasis on risk is clear from the outset, alongside the desire to share accountability with another professional. The significance of accountability was evident in my literature review about detention decisions, such as Peay (2003) focussing on fear of adverse consequences; Quirk et al. (2003) a blame culture; and O'Hare et al. (2013) a risk averse climate. Frank's comments suggest a parallel with the decision at the point of referral for an MHA assessment, yet emphasising the potential to share risk decisions and accountability and therefore by implication reduce assessments (and subsequent

detentions) rather than succumb to the pressure of accountability. Charlie more generally referred to *sharing decisions* with other teams, while Edie mentioned *consult[ing] professionals with knowledge of the situation* as well as gaining *information from people who know about specialisms.* Jean also mentioned *a lot of joint working with [the] specialist dementia nurse* as part of exploring alternatives to an MHA assessment, so the emphasis on these comments is about using collaboration as a way to exploit the specialist knowledge of other professionals. Rhoda extended this point and raised the benefit of a *blue light meeting,* by which she was referring to a protocol developed by NHS England targeting people with learning disabilities or autism, and aiming to prevent the need for admission to hospital by convening an urgent meeting to explore alternatives with the person, their family and a range of relevant agencies involved (NHS England 2015).

7.2.4.11.3 Managing the anxiety of others

The context of the referral being one shrouded in anxiety was suggested by Frank, explicating the implicit pressure to find resolution in assessment and detention. Such pressure has been acknowledged in detention decisions, such as found by Quirk (2007) who identified a form of lobbying by the community psychiatric nurses, and Abbott (2018) who found the referral atmosphere was adversarial. These aspects contributed to the coercion theme in my literature review. Frank emphasised an approach to this anxiety whereby the AMHP shares the concerns but he does not appear to be assuming responsibility for them. He mentioned *acknowledging [the] distress [of the referrer]*, the need for *validation of [their] concerns… [and a] genuine acknowledgement of [the referrer's] concern.* He acknowledged the importance of *invest[ing] time to listen to [the] anxiety of [the] referrer.* This could be an important strategy in the management of pressure in this context.

7.2.4.11.4 Relationships

The quality of the relationship with other professionals gives the opportunity to explore different outcomes. Sián expressed that *relationships with other teams [are] pivotal*. She mentioned *developing good relationships with people [and] teasing out less restrictive options.* She linked the joint visit with collaboration, highlighting this intervention as *sharing not abdicating responsibility.* This is a more explicit reference to the sharing of responsibility introduced above by Frank, potentially as a means to reduce the negative influence of accountability on the decision about whether to co-ordinate an MHA

assessment, but framed in the affirmative as a means to explore less restrictive options in a collaborative way. This focus on the positive and striving for an ideal, while acknowledging the shadow (Fitzgerald et al. 2010), embraces the anticipatory principle of AI in which practice becomes enhanced in a positive direction “like a flower growing toward the sunlight” (Whitney and Trosten-Bloom 2010, p.62). Sián accentuated the increased potential to identify less restrictive alternatives when accountability is shared based on positive relationships with other professionals.

7.2.4.12 Shared understanding with the person

A shared understanding with the person referred was considered important for six participants in order to enhance collaboration, transparency, and ultimately choice. This again embraces a socially constructed reality between the AMHP and person referred. Edie wanted to understand the person’s *values* and their *way of life*. She advocated for *trusting people and giving them options*, but equally *being transparent with [the] person, explaining the concerns of the service.* Charlie equally talked about having *conversations with people* and asking *what’s the problem for them*? He mentioned *sharing the concern and possibilities with the service user.* There is an emphasis on problems rather than strengths which perhaps reflects the nature of the context in which these conversations take place, but highlights the difficulty participants had maintaining an appreciative stance. Frank framed things positively, *valuing people are experts in themselves.*

There were two aspects of collaboration for Sián: firstly she emphasised a desire to understand the situation from the referred person’s perspective, particularly *understanding whether [their decisions were] by choice or not.* This comment suggests she was exploring issues of the person’s capacity to make their own life choices. Secondly, she emphasised the benefit of a joint visit to *highlight concerns to people.* She framed this in the context of providing people with information so they can make an informed choice. Sián’s responses are consistent with the principles of the MCA 2005, including the presumption of capacity; the provision of support (in this case information) to reach a decision; and potentially the acceptance of unwise decisions made with capacity (MCA 2005). These considerations are specific to the MCA 2005 and so do not legally apply to the MHA 1983, but the statutory guidance supports their relevance (DoH 2015, chapter 13.21) and those who advocate for a fusion mental health and capacity law such as Dawson and Szmukler (2006) would share Sián’s perspective on the relevance of these considerations.

7.2.4.13 Joint visit

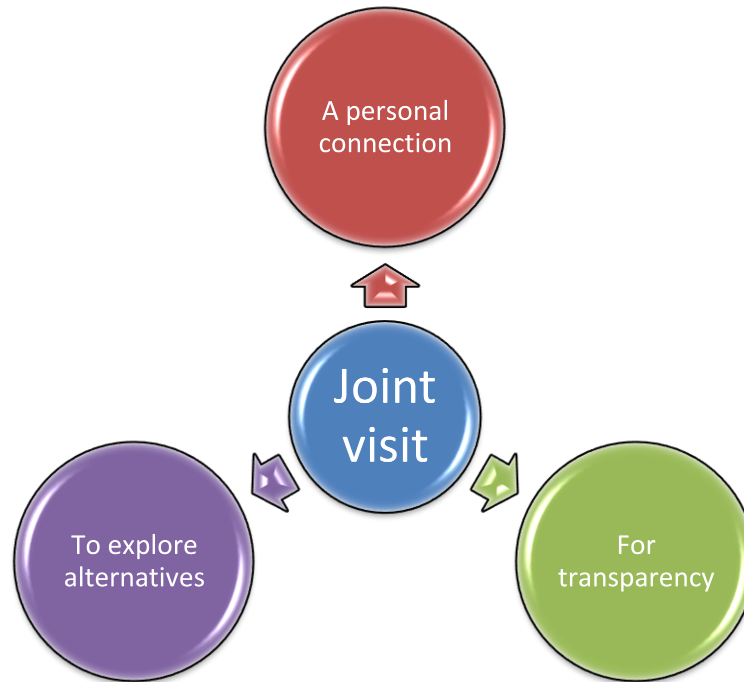

Figure 24: Joint visit theme with codes

7.2.4.13.1 A personal connection

Most participants directly or indirectly mentioned a joint visit in their appreciative interviews. Jake raised about *listening to [the person's] wishes and feelings* and discussing *different scenarios with them*. Charlie advocated for an *advance visit beforehand* in order to establish *information provided by the service user,* emphasising that direct contact with the person referred forms part of the process of information gathering to inform the decision about whether an MHA assessment is necessary. Frank mentioned a *joint visit with the crisis team,* particularly *where information doesn't stack up.* He later referred to a *mismatch in person to on paper* and the joint visit then may be a way of gaining a more accurate understanding of the situation. These comments are consistent with Peay (2003) who found that ASW participants read some case records but then after watching a case video became less sure about the need for detention, supporting the personal connection influencing the decision (encapsulated in my morality theme) and also potentially highlighting how documentation may misrepresent the level of concern.

7.2.4.13.2 For transparency

I referenced earlier the statutory guidance suggesting the threat of detention would invalidate any subsequent consent (DoH 2015, chapter 14.17), offering the counter-view from Szmukler (2018) that most people are likely to prefer being given such information. Edie and Sián both referred to transparency as the purpose of a joint visit, inferring other professionals do not achieve this prior to making a referral for an MHA assessment. Sián highlighted how *sometimes people are taken unawares [about] the concerns* and so the joint visit is a way to *highlight concerns to people*. The focus on concerns again is a departure from an appreciative stance, but the desire for transparency itself is a positively focussed attribute.

7.2.4.13.3 To explore alternatives

The joint visit became a gateway to other services for Jean, who *took [the person] onto [her] caseload.* Sián mentioned the joint visit as a way of *working together [and being] collaborative* with other services. For her it was about *sharing not abdicating responsibility*. Ultimately the joint visit for Sián was about *trying to avoid [detention under the] MHA if possible,* a desire which embraces the anticipatory principle of AI (Whitney and Trosten-Bloom 2010) in which the future is imagined avoiding detention.

7.2.4.14 Documentation/opinion subject to verification

This theme is presented entirely as a cautious approach to the information provided. From my literature review on detention decisions Quirk (2007) found that information from trusted sources was taken at face value, supported by Dwyer (2012) who reflected that AMHPs assess the quality of the judgement of others. The comments are partially consistent with these findings, yet the emphasis is less accepting and more critical suggesting the findings of this study highlight a difference in this respect.

Jake spoke about his knowledge of the person requesting the assessment and whether they are someone who tends to *panic* or *give up easily.* Charlie equally espoused being *critical of the request* and he felt *other's views can be distorted.* Additionally Edie suggested *risks are exaggerated by Health [staff].* Jean, John, and Rhoda echoed these views, with Frank mentioning *where information doesn't stack up*, noting that people are *not as bad as [they] seem on paper.* This suggests meeting the person first and is consistent with Peay (2003) and her findings in relation to detention decisions where ASW's became more sure of their decisions after meeting the person. All these accounts support a critical stance toward the

information provided at the point of referral for an MHA assessment. Again the focus is not appreciative, yet similarly the intention is to scrutinise information in an attempt to avoid needing to assess or detain under the MHA 1983, itself a positive aim.

7.2.4.15 Analysis of risk/protective factors

Figure 25: Analysis of risk/protective factors theme with codes

7.2.4.15.1 Strengths

Sián's appreciative interview exemplifies both this theme and an appreciative stance. She said she considered risk from a *strengths-based perspective*, and she would *look for protective factors to balance risk.* In this way Sián reversed the negative focus on risk to a positive focus on strengths and protective factors. In a similar vein Frank wanted to *tease out what has worked and what hasn't,* so a more neutral view but nevertheless one seeking to uncover former positive outcomes. No other participants mentioned strengths and protective factors in their appreciative interviews, but references to the analysis of risk were common.

7.2.4.15.2 Gaining clarity through criticality

Participant comments suggest a level of analysis and interpretation that ultimately seek to reduce the perception of the *concerns* and *risks*. In this way there is an attempt to neutralise a negative focus at the point of referral through analysis.

Sián emphasised the need to *analyse rather than accept at face value,* while Charlie mentioned that *often we can reduce concerns by analysing the information*. Jake continued the critical stance toward the referral information regarding risk, suggesting risks are often represented *in historical terms rather than actual current risk.* This point echoes Glover-Thomas (2011) and Abbott (2018) who both found historical risks raised current concerns in detention decisions. Frank mentioned the AMHP as the person *who challenges the level of risk,* and that risks *are often presented as higher.* He made reference to situations where *admission might be more harmful,* suggesting a balance of risks which was echoed by Charlie. These comments address an inherently negative focus on risk by taking a critical stance.

The clarity about risk advanced in this theme is contrary to some authors from my literature review into ASW/AMHP detention decisions, where a lack of clarity about risk was pervasive (Sheppard 1990; Glover-Thomas 2011; and O'Hare et al. 2013). Dwyer (2012) however highlighted the fraught nature of the MHA assessment itself, and so a difficulty being clear about risk in this context in unsurprising. It is interesting therefore that AMHP participants in this study felt able to develop a degree of clarity about risk at the point of referral for an MHA assessment, suggesting at this point in the process there is a greater likelihood of clarity than if a full assessment were convened.

7.2.4.16 Acceptance/tolerance of risk/positive risk taking

The final report of the independent review of the MHA 1983 recommended addressing a culture of risk aversion (DHSC 2018), and this was accepted by the government in their white paper (DHSC 2021). This theme is consistent with that desire, advocating for a higher level of risk tolerance. Frank supported a *positive risk view.* He said services *may need to accept risks* and that *sometimes risk is part of who the person is*. This approach adheres to the principles of the MCA 2005, specifically surrounding unwise and best interest decisions (MCA 2005). These considerations do not hold legal relevance in the MHA 1983, but evidently they hold practical implications for Frank in this context, supported by statutory guidance (DoH 2015, chapter 13.21). Dawson and Szmukler (2006) advocated for a fusion of mental health and capacity law to eliminate discrimination and shift the focus away from risk onto decision-making capacity, and Frank's comments are consistent with this perspective. Edie made reference to risks needing to be *proportionate*, suggesting a degree of tolerance of risk prior to resorting to an MHA assessment. She wanted more *positive risk taking* and said *I'm getting better at it,* highlighting how a positive approach to risk is a

development for her and supporting the pervasive culture of risk aversion (DHSC 2021) from which she feels she is evolving. Frank made reference to *when admission just offers containment but doesn't improve [the] situation,* and *trying to influence risks in other ways.* This perspective recognises the limitations of admission and a degree of tolerance of risk while *other ways* are considered. This reflects the purpose principle where admission needs to be for therapeutic benefit (DoH 2015, chapter 1.1).

Sheppard (1990) identified a wide threshold of risk in ASW detention decisions. Later authors identified how knowledge of the person raised the threshold of risk (Peay 2003; Quirk et al. 2003; Glover-Thomas 2011; Stone 2017). Findings from this study appear to suggest a high threshold of risk adopted by the participants, which could be explained by the overwhelming sense of wanting to know more about the person prior to making a decision about whether a full assessment is required.

7.2.4.17 Changing gears and buying time

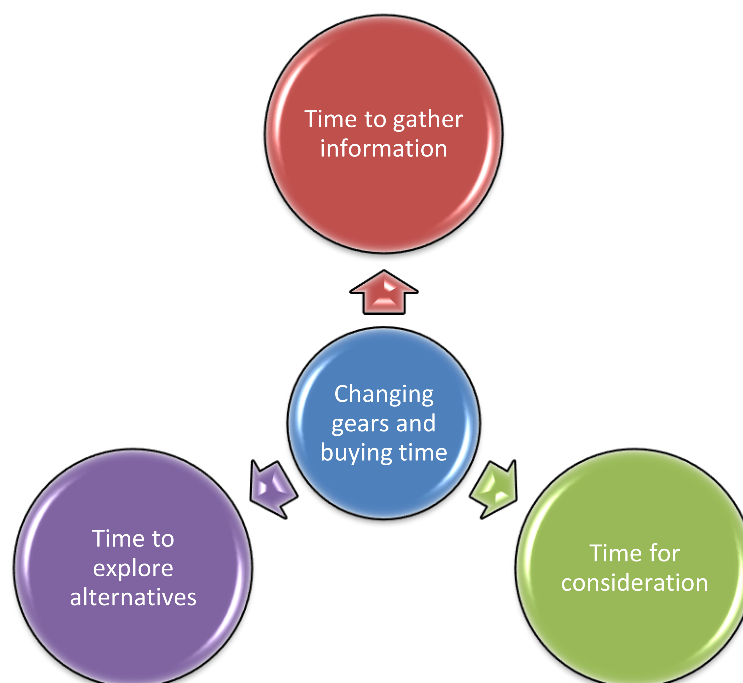

Figure 26: Changing gears and buying time theme with codes

7.2.4.17.1 Time to gather information

There was an emphasis on having more time to gather information and consider alternatives, which is consistent with the desire to get to know the person better first introduced by Peay (2003) in relation to ASW detention decisions. In exploring *actual risks*

and *immediate risk and likelihood* Rhoda highlighted the request for an MHA assessment *doesn't always need an immediate response,* advancing the potential to have *time to gather information,* a consistent desire among participants. Jake for example talked about trying to *slow it down* and *buy time to properly look at the circumstances, the mindset of the referrers and the alternatives available. Time to properly collate information, not be rushed to assess and risk a knee jerk reaction.*

7.2.4.17.2 Time for consideration

Dwyer (2012) wrote about the mental stillness required to reach a decision, and the difficulty achieving this in a fraught MHA assessment process. Edie and Rhoda acknowledged this difficulty by emphasising the benefit of creating space at the point of referral. Edie's preference was for *time to explore and gather, assimilate and process information,* echoed by Rhoda who expressed her desire to *create time to have [a] more considered response.*

7.2.4.17.3 Time to explore alternatives

Participant comments resonate with Quirk et al. (2003) who emphasised a lack of time to organise alternatives to detention as critical in ASW detention decisions, and Kinney (2009) who reflected the challenges of developing an alternative plan in the pressured assessment context. Creating more time prior to entering into a full assessment is one way Charlie, Frank, and Sián overcame this difficulty and enhanced the opportunity to identify alternatives to admission. Charlie for example mentioned the *positive use of time is trying to create more time…. More space to try alternatives…. Space to do something different.* Frank described this as *diplomatic flu*, which he went on to detail was about a need to *acknowledge distress and risks but explain [I] need time to consider*. Frank's sentiments were directed toward finding alternative solutions, advocating a *pathway to assessment that can alleviate [the] crisis* and how if you *put in other help and support [this can] avert [the] need for [an] assessment.* He suggested *slowing [the] response down* and reflected that rushing leads to the *worst assessments.* Frank has inferred that by rushing little time is spent considering options and alternatives. Frank also suggested situations may resolve themselves without intervention: *Build in time and often the crisis passes….* [That it is] *amazing how often things resolve.* This has been anecdotally suggested in two previous observational studies into psychiatric detention decisions (Bean 1980; Quirk et al. 2003).

7.2.5 The contribution to knowledge from the appreciative interviews

This concludes my summary of the examples supporting the shared meanings from the appreciative interview notes. I alluded earlier to the significance of the findings from the mini-interviews, with the appreciative interviews building on the vast data generated at that very early stage in this AI. I have combined the contribution to knowledge from the mini-interviews with that from the appreciative interviews, represented pictorially in Figure 27. These key issues will be integrated into the discussion later in this thesis.

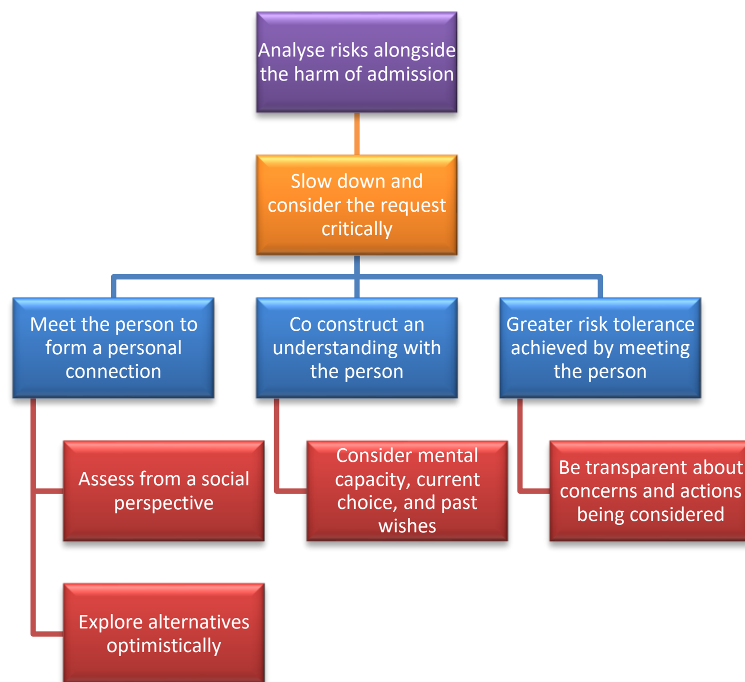

Figure 27: The combined contribution to knowledge from all interviews

7.2.6 Positive Core Map

The culmination of the discovery phase is the illustration or mapping of the positive core, or “the essence of the organisation at its best” (Whitney and Trosten-Bloom 2010, p.164). The AI up to this point had been about recognising the best of practice now with regard to AMHP decisions at the point of referral for an MHA assessment, with this positive core map seeking to visually represent how AMHPs conceptualise their practice in relation to this decision, a decision largely ignored in legislation, guidance, and research. The positive core map is therefore a visual representation of the findings from the discovery stage of this study.

We gathered as a group to draw a map of the positive core of AMHP decision-making at the point of referral for an MHA assessment (see Figure 28). I had not anticipated enthusiasm for this venture but in the event the participants embraced the opportunity. The image depicted was the first and only draft, highlighting a level of decisiveness and agreement predicated on the extensive discussions that preceded this stage in the AI process.

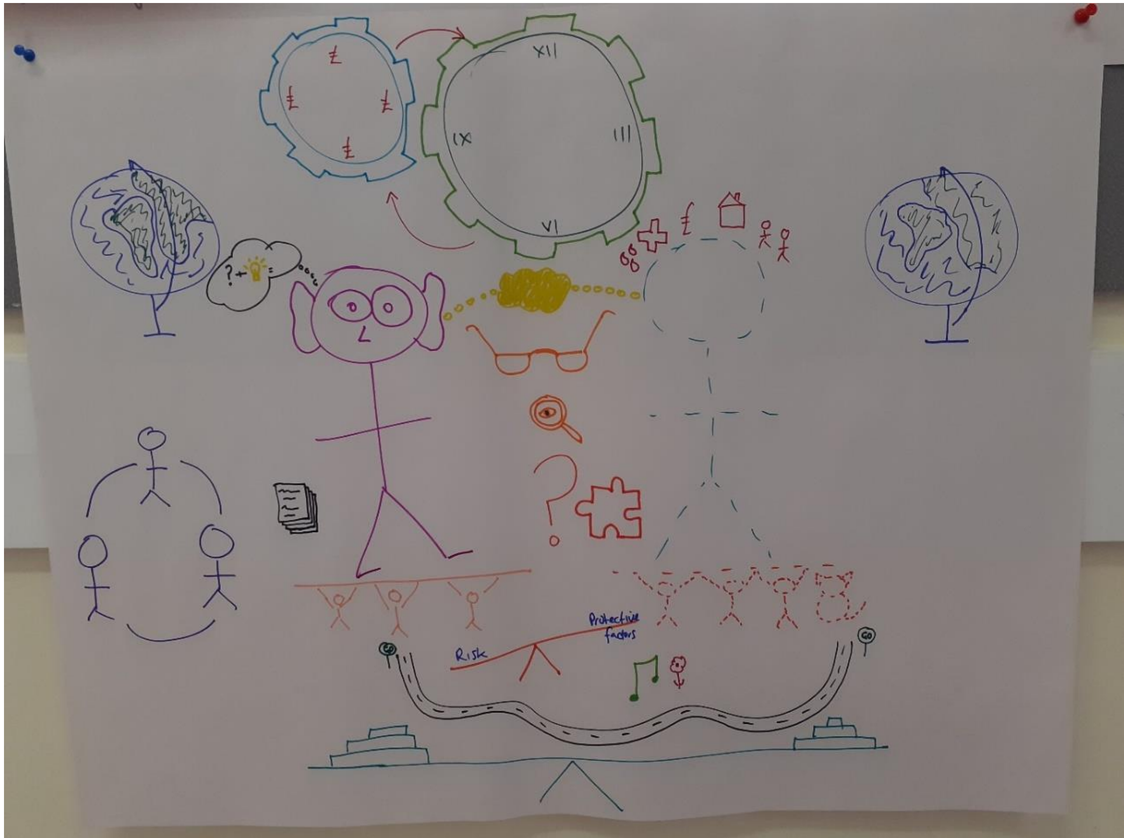

Figure 28: Positive core map

We started by drawing the AMHP and the service user at the centre of the picture, which is consistent with keeping the person at the centre of our decision-making as detailed in our affirmative topics. We placed ourselves in the centre with the person referred. My interpretation of this aspect of the picture is that we valued a connection with the person referred, supporting our desire from the appreciative interviews for a joint visit. This finding also reflects a desire identified in my literature review that AMHPs wanted to get to know the person before making a decision about detention (Peay 2003), and seeing the person reduced the likelihood AMHPs wanted to detain them (Peay 2003).

The AMHP was given big ears and eyes to represent them listening and gathering information, consistent with both our affirmative topics and the socially constructed shared meanings from the appreciative interviews. The service user was drawn in dotted lines to

show they were not clear to the AMHP at this stage of the decision-making process, though the overall purpose of efforts at this stage were to gain greater clarity. This arose in the appreciative interviews, with participants gaining clarity about risk through analysis of the information. Uncertainty was common in AMHP detention decisions (Peay 2003; Skinner 2006; Glover-Thomas 2011; Buckland 2016), but this process of gaining greater clarity at the point of referral for an MHA assessment is a new finding in this study supporting the value of a greater focus on the referral stage.

The bubble between the AMHP and the person referred represented transparency and the shared socially constructed understanding between the AMHP and service user, both issues arising in our shared meanings from the appreciative interviews. These two issues are important findings from this study: transparency was discussed at length in the appreciative interviews, notable due to the aforementioned potential conflict with the Code of Practice (DoH 2015, chapter 14.17); and a shared understanding supports a focus on collaboration with the person referred, elevating this above risk. This desire complements the desire for a personal connection inferred above by the closeness of the AMHP to the person referred, and supports the findings from my literature review that this connection lowers the likelihood of detention by raising the AMHPs risk threshold (Peay 2003; Quirk et al. 2003; Glover-Thomas 2011; Stone 2017).

The glasses represented the different lenses from which the AMHP views the service user, one of the shared meanings from the appreciative interviews. The question mark highlighted being open to all possibilities, both an affirmative topic and a shared meaning. The jigsaw piece, magnifying glass, and the pages represented the analysis and scrutiny of information, aspects of both the affirmative topics and shared meanings. The bubble with the lightbulb represented intuition, one of our shared meanings arising from experience and repeatedly relevant throughout many of the other shared meanings. Intuition was equally an aspect of detention decisions giving rise to this sub-theme in my literature review (Glover-Thomas 2011; Dwyer 2012; Buckland 2016; Morriss 2016a; Stone 2017; Fistein et al. 2016).

Beneath the AMHP are their peers, holding them up to represent the support they offer. To the side their partnership working with others, both arising as shared meanings and consistent with the literature about AMHP detention decisions in two respects: firstly that peer support was valued (Quirk et al. 2003; Gregor 2010) and secondly that coercion was identified as a sub-theme (Haynes 1990; Thompson 1997; Thompson 2003; Skinner 2006;

Quirk 2007; Kinney 2009; Campbell 2010; Abbott 2018), with partnership representing the antithesis to this issue.

The globe for both the AMHP and service user represented the essence and uniqueness of the person, a holistic representation, both an affirmative topic and a shared meaning. We initially added this to the service user but felt it also applied to the AMHP, reflecting their personal and professional experiences and acknowledging the human element to the decision. This echoes the morality theme constructed in my literature review, and further adds to the personal connection implied by the AMHP being in the centre of the picture with the person referred.

The people beneath the service user are their social and family networks, again pictured holding them up to illustrate their support (including animals hence the image of a cat) reflecting aspects of the social perspective included in the shared meanings. Again, these are dotted because they are unclear to us at the point of referral. Around the service user's head are a number of images representing different aspects of their life, reflecting the decision is holistic. These were not meant to be comprehensive, but to acknowledge each person would have a range of issues that would be important to them. We included housing, finances, social supports, distress, and medical issues. These are again reflected in the shared meanings.

Above the AMHP and service user we drew some cogs in the form of clocks, one with pound signs. This represented the AMHP trying to buy time and the notion of shifting gears, both an affirmative topic and a shared meaning. This features prominently in both size and location (top centre) in the picture which was not a conscious decision but may reflect the impact of intuition generated through creative means (Whitney and Trosten-Bloom 2010). These concepts did give rise to a lot of discussion in the workshops as participants struggled to deconstruct the importance of their meaning. Further analysis of the notes from the appreciative interviews highlighted the importance of time for information gathering, analysis and exploring alternatives, all linked to meeting the person referred and by extension raising risk thresholds and improving clarity. All these factors may be related back to the AMHP responsibility to explore "all the circumstances of the case" (MHA 1983, s 13(2)), and to bring a social perspective to the detention decision (DoH 2015, chapter 14.52). The prominence of time and the way the AMHP influences time to create opportunity in the positive core map gives additional weight to the notion that the AMHP

may have a greater opportunity to enact their role at the point of referral for an MHA assessment than in the assessment itself.

Beneath the service user and AMHP we drew scales balancing risk and protective factors, a shared meaning from the appreciative interviews. We included music and a flower (for nature) next to protective factors to represent some factors that could be protective, but recognising these could be anything. The notion of accepting risk formed part of this aspect of the drawing as depicted by the scales, incorporated in both affirmative topics and shared meanings. We added a road with "Go" signs at each end further representing the collaborative nature of the decision with the service user, and beneath it all the scales to represent how everything is then balanced to reach a decision. The notion of balancing arose in the affirmative topics and shared meanings, but broadening this balance to incorporate everything across the bottom of the picture is another way this creative method of data collection has enriched the study by drawing on a notion that wasn't previously put into words.

7.3 Dream

After we completed the positive core map we moved onto the dream stage of AI, which "lifts up the best of what has been and invites people to imagine it even better" (Whitney and Trosten-Bloom 2010, p.177). This is the second 'D' in the 4-D cycle (Whitney and Trosten-Bloom 2010) and begins the process of turning all the positivity about practice now into something tangible that shapes practice in the future. At this point in the AI process the traditional essence of research which seeks to define the experience of interest was complete, but speaking as a practitioner myself, the value of research begins to become clear when it is translated into practice. The aims of this research stated in chapter one were:

1. To illuminate AMHP decision-making at the point of referral for an MHA assessment.
2. To generate knowledge and understanding of AMHP decision-making at the point of referral for an MHA assessment.
3. To offer AMHPs an opportunity to make use of this new knowledge and understanding in a way that is meaningful for their practice.

Aims one and two had been achieved in the discovery phase, and to some extent aim three also. The process of illuminating the best of practice clarified and validated practice for participants, something which was meaningful for their practice. However the focus of the

dream, design and destiny phases was to actualise aim three further, which may be viewed through the lens of pragmatism.

7.3.1 The collective dream

Dreaming in this AI comprised three stages: defining the collective dream; enacting that dream; and developing a mind map of the desired future (see Figure 29).

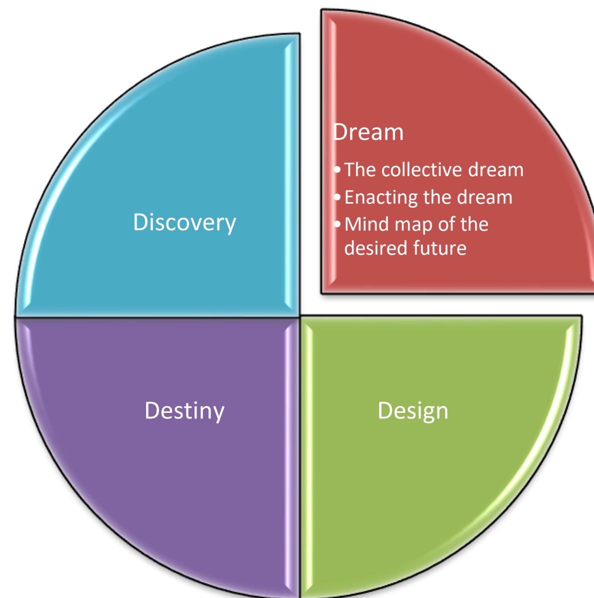

Figure 29: The dream process

The process formulating the collective dream started with the focal question adapted from Whitney and Trosten-Bloom (2010) and detailed in Box 3.

> *It's 20-years from today, legislation and resources remain largely the same but there have been changes that have improved the way services work with people with mental illness. What's happening now when someone reaches a crisis point in their mental health? How are AMHPs approaching the decision about whether to proceed with an MHA assessment? What decisions and choices did AMHPs make to pave the way for these changes?*

Box 3: Focal question

We spent time on this individually then moved straight to a whole group discussion to clarify the collective dream. There was a sense by this point that separating into small groups then forming a larger group was unnecessary given the small number of

participants. We considered we were still able to achieve the basic principles of nominal group technique (Van de Ven and Delbecq 1974), with each of us considering our own perspectives and then bringing these views to the group, allowing each member to express their views and discussing concepts until a synthesis of the whole narrative was achieved. The completion of this collective dream in draft concluded the second workshop, with participants agreeing earlier in the day that given the process was taking longer than anticipated they would be happy to have a fourth workshop to ensure the AI process could be completed thoroughly. Our first task for day three would be to review and finalise the collective dream, which we felt was not quite complete.

Prior to the third workshop England entered a second national lockdown due to an escalation of coronavirus. I contacted participants to check whether they would like to delay the third workshop or proceed in an online format. There was an agreement that to maintain the momentum it would be better to proceed online. This required an amendment to my ethics approval which I obtained, including updating my participant information and agreement (see appendix ten).

Day three began with me reminding participants of the ground rules, followed by reviewing the progress achieved in workshops one and two. We then returned to the collective dream and as a group refined what we had achieved in workshop two. The agreed collective dream is detailed in Box 4.

1. Services are holistic and person centred.
2. Services work collaboratively with people.
3. There is a graded pathway with earlier involvement of an AMHP, including directly with the person and a “blue light” meeting process.
4. Extended calm café / psychiatric A&E with social worker/AMHP/psychiatrist input/nurses.
5. Robust crisis plans that includes collaborative input from the person.
6. Joint working.
7. Joint resourcing.
8. Education/understanding.
9. Person-centred language.
10. Culture – society and service. Acceptance, parity, a rights-based approach, capacity, shared and supported decision-making.

Box 4: Collective dream

The collective dream developed in Box 4 has clear links to the positive core of AMHP decision-making at the point of referral for an MHA assessment now, with some aspects

extended and considered aspirational due to the necessity for other professionals and services to adapt their approach. Notions of being holistic, person-centred, and collaborative with the person are all aspects of current AMHP practice, though participants felt somewhat isolated in this venture now and wanted to see other *services* more aligned with this approach. This is despite a clear intention for all mental health services to be operating in this way (Mental Health Taskforce 2016). This finding suggests that AMHPs may be at the forefront of mental health policy implementation when it comes to person-centred care.

The identification of a graded pathway was a formalisation of what AMHPs see themselves trying to achieve now, but the desire was for this to be accepted by other agencies as part of the process, rather than current practice where AMHPs are trying to achieve this against a pressure to make decisions more quickly. This notion of a graded pathway is key to the desire for creating more time to explore other options. This is new knowledge generated from this study, supporting a narrative that sees AMHPs as part of a system that supports people remaining in the community rather than one that seeks to detain them in hospital. Participants included earlier involvement to allow for direct contact with the person referred here, associating strongly with the joint visit and creation of more time to explore alternatives, consider the situation more thoroughly, and connect with the person. These are all prominent aspects of the positive core and the desire for other services to adopt these priorities was the dream.

The inclusion of a *blue light* meeting in the process emerged in the appreciative interviews as a way of sharing decisions and collaborating with other services to prevent the need for admission. This was seen as aspirational as often the pressure from other services is on the AMHP to co-ordinate an assessment and so there is little motivation from referring agencies to engage in a process of trying to avoid an assessment and admission, despite the community care rhetoric (NHS 2019). It was felt that learning disability services, who already use blue light meetings to find alternatives to admission, have acknowledged that admission is something to be avoided as far as possible, but mental health services do not share this view despite the principle of least restriction (DoH 2015, chapter 1.1). Participants wanted to see mental health services taking a more holistic view of people's needs rather than focussing so heavily on admission and medical treatments. The dominance of the biomedical paradigm in the practice of mental health services is inferred here, yet internationally the desire is for less coercive mental health care (UNCRPD 2006).

Through this dream AMHPs in this study are seeking to share their drive toward alternatives to admission and by so doing strive to widen support for less coercive care.

The extended calm café or psychiatric A&E was reflective of the importance of alternatives to admission, something which featured throughout many aspects of the shared meanings and the positive core of AMHP decision-making now. This was equally supported in my literature review as a dominant theme in AMHP detention decisions. The focus here was on extending current resources to provide services that offer a realistic alternative to hospital admission. The calm café is a local reference to a service that while helpful was felt to be targeted at people who are relatively well rather than those who are at risk of needing admission to hospital. These services are cited in the NHS long term plan (2019) and are viewed as alternatives to attending A&E departments, but the feeling among participants is that they could be utilised to avoid the need for detention in hospital also if adequately resourced. Bonnett and Moran (2020) researched AMHP views on the reasons for the rise in the number of people being detained, with a key finding that more crisis services operating as alternatives to admission are required. This aspect of the collective dream shares this aspiration.

The desire for a *robust* crisis plan was an expression that while crisis plans are currently in use they are not sufficiently helpful. Collaboration in their development was emphasised in line with the positive core and shared meanings from the discovery stage of this AI.

Joint working and joint resourcing were considered aspirational, with participants feeling often the AMHP has to work hard to achieve a collaborative approach with other services, and services to prevent admission are often not provided because agencies are not clear who should fund them. The link to alternatives to admission is clear here.

Education and understanding was primarily about the AMHP role, driven by a feeling that other services view AMHPs as getting in their way rather than fulfilling the role that was intended for them. This can be linked to coercion which I identified as relevant to AMHP detention decisions, albeit education was the positive way of framing this issue aligned with the appreciative focus of the methodology. When framed in this way it is interesting to reflect on this point. The AMHP participants in this study felt it was important for wider mental health services to understand the AMHP role better, yet this role has remained unchanged since 1983 and arguably further back than that (see chapter two). AMHPs bring a social perspective to decisions about detention (DoH 2015, chapter 14.52) and they are

guided by the Code of Practice (DoH 2015, p.12), yet this is also available and considered beneficial to other people, including mental health professionals. Additionally it has been openly acknowledged that too many people are detained in hospital (DHSC 2018) and that improved crisis services are required to provide mental health care in the community (NHS 2019). As mentioned above the sense from participants that services needed to be educated to understand what the AMHP is trying to achieve in their role supports again a notion that AMHPs operate at the forefront of national policies that advocate for community-based less coercive mental health care.

Person-centred language was highlighted as important because participants felt without this services often depersonalised detention, focussing on factors such as risk and treatment. Again this collective dream was about encouraging other services to adopt an approach to people that participants felt AMHPs had already adopted, represented clearly in the positive core.

Finally culture was discussed at length and was somewhat difficult to encapsulate. Principally the feeling was that a shift was required in societal perspectives that moved the emphasis away from responding to mental health problems with coercive hospital-based interventions to a more collaborative approach.

7.3.2 Enacting the dream

The protocol for the workshops was to then enact the collective dream as a play, each adopting a role within a fictitious scenario of their own construction containing the elements of their collective dream. We considered the group small enough to do this as a whole group, and from one of the suggestions arising in the collective dream decided to enact a 'blue light' meeting. In advance of the AI workshops I had summarised an example referral based on a real scenario for use during the workshops should a scenario be needed. This scenario was developed to be used at any point to generate discussion. I suggested this scenario could be used as the basis for the blue-light meeting, to which the participants agreed. The scenario is detailed in Box 5 and was shared on the screen for participants to read prior to the meeting enactment. The enactment was a fluid process, with all participants being used to attending meetings to discuss different options for people, this enactment being less constrained however with the development of a more creative plan than may be achieved in practice, detailed in Box 6.

Scenario: *Female in her late 30s, lives with her 14-year-old son in a village with her mother around the corner. Her brother has come to stay while she isn't well to support her. She believes her central heating boiler is poisoning her with carbon monoxide. The same is true of the boiler at her mother's house. She keeps calling the fire brigade. She went to the village post office to escape poisoning. She was detained under s136, assessed, agreed to home treatment and was discharged. Immediately on discharge she called an ambulance due to carbon monoxide poisoning. She also "tampered" with the boiler. She is accepting 200mg quetiapine but largely because her brother is coercing her to take it. She doesn't think she needs it and is concerned about having too much medication due to a previous experience. Her brother can't cope with her anymore and her mother feels the same. Home treatment team feel they can no longer home treat. That said they are seeing her daily.*

Additional information gained: *Her son has gone to stay with his father. Medication is prescribed by the GP. She has not been seen by a psychiatrist apart from at her s136 assessment. Her 200mg quetiapine comprises of eight 25mg tablets despite higher mg tablets being available. 200mg is not a therapeutic dose for psychosis, rather this would be a minimum of 400mg. Mother and brother can't cope principally because they are all staying at mother's house and she keeps waking mother and brother up to check they are still alive due to fear they have fallen prey to carbon monoxide poisoning. When she was detained in the place of safety, she felt safe from poisoning and was more relaxed for her assessment there. The tampering with the boiler consisted of her taking a screwdriver to the cover but being unable to remove it.*

Box 5: Creative enactment

The plan developed in Box 6 focussed on avoiding the need to progress to an MHA assessment and admission to hospital.

- Practical intervention – service the boiler.
- Bring in an alternative support network for the person and their family.
- Encourage the use of a calm café or psychiatric A&E – a safe place to explore concerns/issues. Could extend to the use of a crisis house.
- Consider changes to treatment. Example was too many individual tablets.
- Explore physical health issues either at home or at the calm café.
- Clarify risks.
- General support for earlier involvement of the AMHP service.

Box 6: Plan developed

The starting point was a practical intervention with regard to the boiler, the primary purpose being to address the person's worries about poisoning. This can be linked to the positive core, with the AMHP listening to the person and working collaboratively with them. The boiler was her priority and while her concerns were not considered to be realistic by those around her, participants felt these concerns should be heard.

Then there was a focus on support for the person and their family, which it was felt could alleviate some of the mounting pressure toward hospital admission. Emotional support for the person referred was one aspect given her distress, but of equal importance was support for a family who were struggling. This is reflected in the positive core where the importance of support networks are illustrated as holding the person up. In my literature review I referred to Abbott (2018) who identified the ability of family to cope with the person was decisive in detention decisions, and this aspect of the plan replicates this finding.

Linked to the collective dream and a pathway to admission the plan developed included use of alternative resources in a stepped way. There was discussion about how the home environment was fraught and so seeing the person in a safe place away from home where other professionals could offer support and services might be more productive than trying to bring services to the person at home. The mention of the crisis house was an acknowledgement that an alternative to hospital where the person could stay overnight might be helpful as the person had identified feeling safe when detained in a place of safety previously, albeit the desire was to offer this option as a way of working collaboratively.

Medication was considered as part of the response, but there was a sense that in order to enable the person to understand the levels of treatment recommended for a therapeutic response adjustments would be required in the way this was prescribed. It was considered unhelpful to issue so many smaller dose tablets as this could create the impression for the person that they were on a high dose of treatment. The number of tablets was seen as critical therefore to the perception of dose, with the current prescription misleading the person. This was ultimately about transparency and a shared understanding as illustrated in the positive core.

Physical health was equally considered important as this could impact the person’s experiences. Indeed participants wondered whether the person might be right about being poisoned and there was concern her worries may have been dismissed due to a belief she was mentally unwell. Participants felt these issues could be explored alongside mental health concerns in a holistic way.

Clarity about risk was considered important, echoing the emphasis on risk in detention decisions from my literature review, and also the positive core where risks were balanced

against protective factors. The positive core emphasised a lack of clarity through the use of dotted lines, and the shared meanings provide the context that much of the information gathering, collaboration, and analysis centres around bringing greater clarity to the decision. This provides further support that clarity is enhanced at the referral stage where this hasn't been demonstrated as possible with detention decisions themselves.

The support for earlier involvement of the AMHP service recognised the value AMHPs bring to avoiding the necessity to use coercive powers. This aspect of the plan was not specific, rather a reflection on how often the AMHP service is contacted too late when they are less likely to be able to influence a situation in a positive way. This formed part of the collective dream and was emphasised here to illustrate with this referral example how beneficial our involvement could be if introduced early enough.

Following the creative enactment of a blue light meeting we summarised the themes from this meeting as a whole group, which while closely representing the plan was developed as a more generic summary that could apply to any given situation. The themes developed are detailed in Box 7.

1. Earlier involvement of AMHP service.
2. Practical intervention.
3. Alternative support network.
4. Safe environment – calm café, crisis house.
5. Multi-disciplinary home treatment team with support arm. Care co-ordinator central point for person. Includes treatment review and physical health.
6. Clarify risks and consider ways to mitigate.
7. Explore antecedent.

Box 7: Themes from the collective dream

These themes can be clearly related to the plan discussed in the previous section and so require little additional explanation. The aspect that attracted some further discussion not incorporated in the plan was point 5 and the emphasis of a *multi-disciplinary* home treatment team with a *support arm.* It was considered that the focus of home treatment was medical and a multi-disciplinary approach would value other perspectives. Equally home treatment was envisaged to be something more supportive than the current service provision, linking back to the practical intervention listed in point 2. Included in this point was the central role of the care co-ordinator, which participants felt was currently lost where people can move between services without a thread of consistency. While not

specifically related to the role of the AMHP, this point values the relationship and a collaborative approach espoused in the positive core and therefore envisioned more widely for the service.

7.3.3 Mind map of the desired future

To conclude the dream phase of this AI we sought to produce a mind map of the desired future. This was more challenging to achieve online than it would have been had we all been in the same room together. I set up a whiteboard and paper behind me so the participants could see the map as I drew it based on their suggestions, however the image was quite small on their screens. Nevertheless the pictorial representation appeared to convey the central themes we had developed above, as depicted in Figure 30.

In the mind map the person is closely supported by their keyworker, with the AMHP service surrounding them followed by a multi-disciplinary blue light meeting process all aimed at developing plans as an alternative to hospital admission collaboratively with the person. The interconnecting lines became difficult to define as all aspects were deemed important in exploring alternatives, but the person's family remained a central part of any plan.

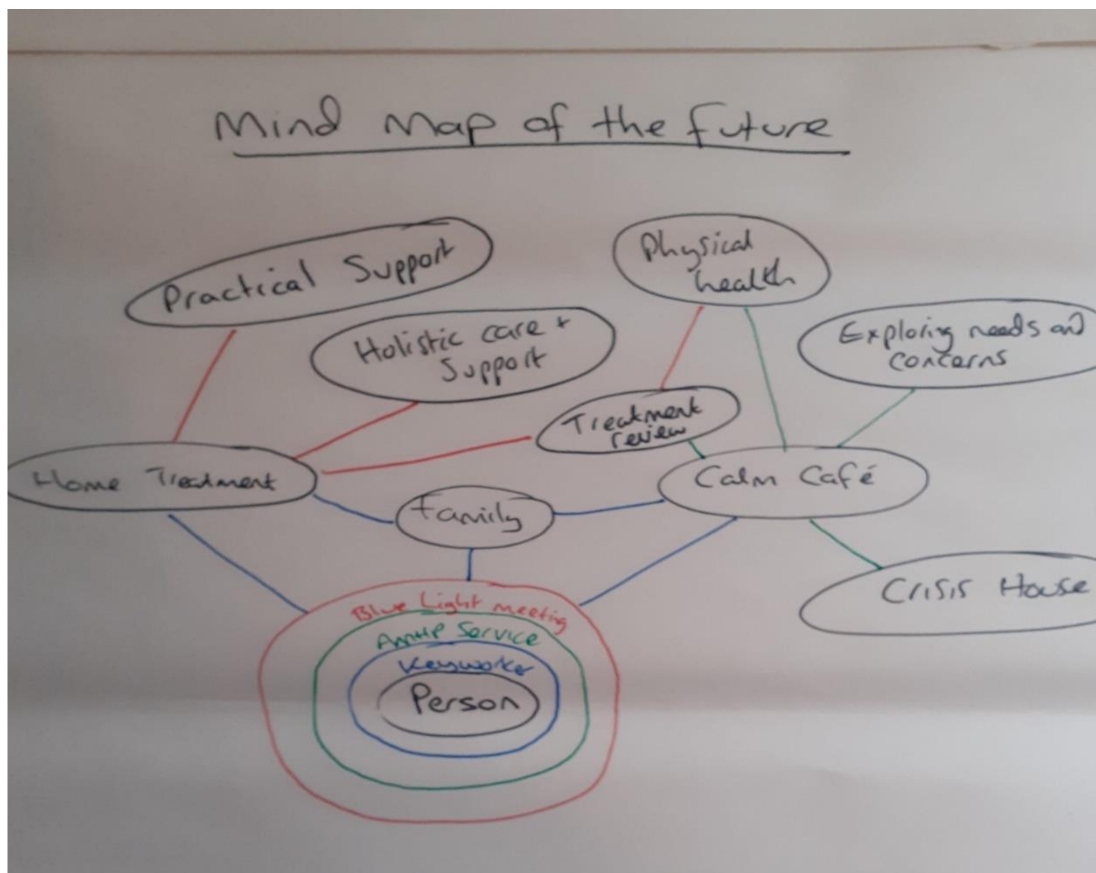

Figure 30: Mind map of the desired future

7.3.4 New knowledge from the dream stage

This mind map offers one way of representing the data from the dream stage of this AI, but building on my subsequent analysis following the workshops there are clear links back to the mini-interviews and appreciative interviews of the discovery phase. Earlier I drew out key messages from the data that represent the new knowledge generated through this study, depicted in Figure 10 and Figure 27. The dream stages builds on these findings setting the trajectory of how AMHPs see services operating in the future (see Figure 31).

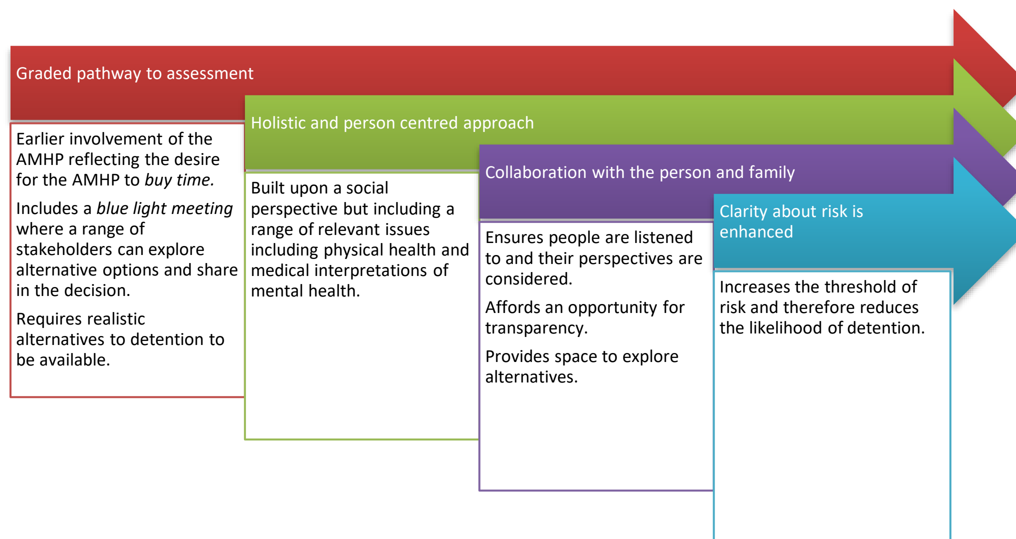

Figure 31: New knowledge from the dream stage

Defining the positive core of AMHP decision-making at the point of referral for an MHA assessment, then dreaming about how to promote the achievement of the positive core every time is the accomplishment of the new knowledge generated from this study. Participants had already defined the best of their practice, and imagined a future that would support the achievement of this best. No other research has focussed on this decision and as such the knowledge generated gives the first insight into this hidden experience. For the participants this was the first time they had sought to clearly define what they thought their best practice looked like, and the process of doing this was powerfully clarifying and validating. Participants constructed a reality of their practice through this research. The design and destiny phases gave participants the pragmatic opportunity to explore how the service might support them to achieve their newly clarified dream for the referral stage. The remainder of this chapter therefore is dedicated to a

more localised and practical application of the new knowledge gained, rather than on the development of any further new understandings about the phenomena. The next chapter will provide greater discussion of the new knowledge generated from this study.

7.4 Design

We then moved onto the third 'D' in the 4-D cycle, the design phase (Whitney and Trosten-Bloom 2010). The purpose in this phase was to begin to formulate a plan to embrace the best of practice identified in the discovery phase, and consider how to implement the collective dream from the design phase. This phase was completed in two steps: firstly, strategic design elements were identified in order to target the destiny phase on specific aspects of the service; then, provocative propositions were developed for each identified design element. These propositions were intended to focus the interventions in the destiny phase.

7.4.1 Strategic design elements

Participants were asked in small groups to consider what design elements of the AMHP service, such as policies, procedures, and accepted working practices impact upon achieving the desired future. Small groups then collectively compared these elements and agreed a final set of strategic design elements specifying ideals for each design element as detailed in Box 8.

1. How we manage referrals and include the person and all relevant others.
2. How we involve other services in the decision.
3. How we allocate work to enhance continuity.
4. How we educate other services about our role.

Box 8: Strategic design elements

7.4.1.1 How we manage referrals

This was focussed on how the service would recognise and promote the desire for the AMHP to work in a way that would achieve the positive core every time. Participants felt the support of the service was essential to achieve this. Key to this service design element was the inclusion of the person and relevant others, which participants felt required an understanding on the part of the service that to achieve this AMHPs would need to be given sufficient time to respond to referrals in this comprehensive way. While it was felt this was sometimes possible it was also felt that there were times this was less possible due

to the demands placed on the service. This strategic design element is intrinsically linked to changing gears and buying time from the shared meanings and the positive core map.

7.4.1.2 How we involve other services in the decision

This was a direct way of highlighting the decision needs to be shared. While legally it was acknowledged it is the AMHP's decision about whether an MHA assessment is necessary or not, the feeling was that other services should contribute to this decision and share the AMHP's desire to avoid detention wherever possible in line with the statutory guidance about least restriction (DoH 2015, chapter 1.1). While individually participants felt AMHPs seek to do this as much as possible, it was felt the service could promote this by establishing multi-agency agreements about pathways to assessment under the MHA, encapsulated in the collective dream and the enacted *blue light* meeting.

7.4.1.3 How we allocate work to enhance continuity

This was a reflection of the benefit of knowing the person, and an acknowledgement that sometimes referrals are passed between AMHPs when situations are managed over more than one day. The essence of collaboration and shared understandings from the positive core are encapsulated in the recognition that decisions at the point of referral for an MHA assessment require continuity.

7.4.1.4 How we educate others about our role

This was a return to the collective dream where it was felt that other services needed a better understanding of the AMHP role. It was felt that when AMHPs are dealing with other agencies who have made referrals often the atmosphere was not conducive to explanations and education, echoing the findings from Abbott (2018).

7.4.2 Provocative propositions

Participants were given guidance that provocative propositions are expressed as a future ideal that already exists; they are based on best practice as identified in the discovery phase; they stretch practice beyond what is currently achieved; and they move practice to where they want it to be (Whitney and Trosten Bloom 2010). We then broke into two smaller groups each taking two design elements to develop the provocative propositions for. One group developed provocative propositions for design elements one and two, while the other developed them for design elements three and four. The whole group then reconvened to discuss the provocative propositions developed, agreeing them as detailed

in Box 9 to conclude the third workshop. These provocative propositions represent the essence of hopefulness and pragmatism, or meliorism, advanced by Koopman (2006).

1. The triage AMHP will listen to concerns, discuss the concerns with the person and relevant others to explore whether an AMHP will consider the persons case further.
2. All involved professionals will be invited to contribute to a plan with clear agreed outcomes and actions.
3. Work is allocated following a principal of continuity, either where the worker knows the person best or they have relevant expertise with the issues faced by the person referred.
4. We have leadership roles with other services to work positively with them on an ongoing basis, so they understand our role.

Box 9: Provocative propositions

7.4.2.1 The triage AMHP will listen to concerns, discuss the concerns with the person and relevant others to explore whether an AMHP will consider the persons case further.

This proposition centres around the creation of a *triage AMHP* role as part of the AMHP duty system and was designed to bring in elements of collaboration and partnership with the service user, their family, relevant others and partner agencies. The focus is on being analytical, holistic and person-centred. It promotes early involvement of an AMHP, and seeks to gain clarity about risks, where possible 'buying time' for a more considered response. The bespoke nature of the *triage AMHP* role values this part of the process, allowing that AMHP to focus only on early intervention rather than fitting this aspect of the role around other commitments that often take precedence otherwise. The joint visit forms part of this role, connecting the AMHP with the person referred and the people and agencies involved. Shared understanding is promoted. Transparency is enhanced through open conversations with the person referred to enable them to contribute to a decision. Time is spent analysing information to gain a balanced perspective. Use of safe places may also come into this as discussed in the collective dream. This proposition exemplifies almost all aspects of the mini-interviews, appreciative interviews and the positive core, further integrating aspects of the collective dream. Participants felt the word *concerns* was required despite the appreciative focus of the study because the reality of practice is that referrals are always made with a set of *concerns* attached which should not be disallowed.

In using the term *concerns* participants felt the appreciative stance could then be applied to realign the response to the positive, turning toward problems and then addressing them through positive dreams (Bushe 2010).

7.4.2.2 All involved professionals will be invited to contribute to a plan with clear agreed outcomes and actions.

This proposition focusses on partnership work and builds in the notion of a graded pathway to assessment under the MHA, adopting a rights-based approach that views detention as a last resort. It builds on the first proposition and further contributes to achieving the key elements drawn from the mini-interviews, appreciative interviews, and positive core. It draws support for the decision from partner agencies, suggesting something aligned with the *blue light* meeting from the collective dream, but not restricting options to this ideal acknowledging that this would require agreement from partner agencies, something outside of our control in this study. Participants felt an *invitation to contribute* in whatever form this then took would be an achievable goal. The proposition would enable the AMHP to view the situation from a range of perspectives, encouraging this openness in others also. A shared forum would provide a space to work in partnership to balance and share risks, in this way promoting positive risk taking and considering ways to mitigate risk other than detention. Creative and practical solutions could be agreed and implemented, including considering alternative support systems.

7.4.2.3 Work is allocated following a principal of continuity, either where the worker knows the person best or they have relevant expertise with the issues faced by the person referred.

This proposition recognises that knowledge of the person and a relationship with them enhances decision-making, echoing the findings from my literature review in relation to AMHP detention decisions. It maximises a person-centred approach and enhances collaboration and transparency. It proposes drawing on experience and expertise where knowledge of the person is absent, returning to the shared meanings from the appreciative interviews where experience was first highlighted as a key theme. The shadow of this proposition is an implication that this is not currently being achieved as much as the participants would like due to the way the service is structured around a duty rota system. Linked to changing gears and buying time, often it was felt referrals led to pieces of work that might span more than one day in which case situations would then have to be passed

to another AMHP to continue to explore. There was however a sense that the *triage AMHP* role could be planned in a way that enabled people to have successive days on duty followed by longer periods not on duty to partially address this issue.

7.4.2.4 We have leadership roles with other services to work positively with them on an ongoing basis, so they understand our role.

This proposition promotes understanding of the AMHP role as detailed in the collective dream, recognising that part of the challenge for the AMHP is managing a misunderstanding of the role by others. Abbott (2018) referred to the referral stage as adversarial, and so this proposition seeks to reverse that negative focus. The proposition seeks to "buy time" by encouraging early intervention from the AMHP service and a partnership approach. In this way it promotes a rights-based approach and contributes to culture change. Enacting this proposition supports all the other provocative propositions.

7.4.3 Summary of the design phase

The design phase lay the foundation for the destiny phase in which actions were then developed to enact the provocative propositions. The above has given the detail of those provocative propositions, but a simplified visual representation provides a useful way of conceptualising what the next phase will be built upon (see Figure 32).

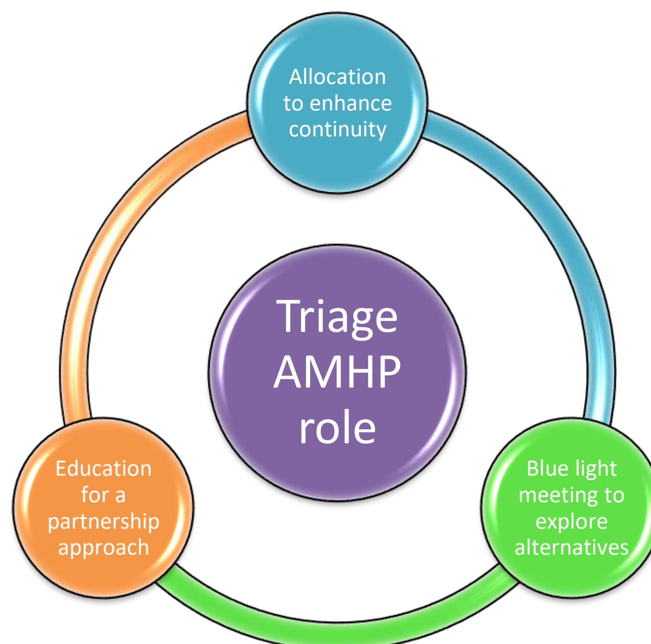

Figure 32: Design phase summary

The emphasis is on the *triage AMHP* role for this is where the positive core is enacted, with allocation for clarity enhancing this and convening a multi-agency meeting giving the *triage AMHP* scope to explore alternatives to admission in partnership with other agencies. Education supports the whole process because services understand what the AMHP is trying to achieve and begin to work in a way that enables the AMHP to fulfil their role, such as with earlier intervention and amended expectations.

7.5 Destiny

The destiny phase commenced on day four of this AI, and the session was concluded by lunchtime. The purpose of the day was to conclude the final phase of this AI, specifically to develop an implementation plan for each provocative proposition, essentially a list of tangible actions. We approached this task as a whole group which was a deviation from the initial protocol but participants felt accustomed to the process and considered the group small enough to manage as a whole. In developing the plan it felt as though the thinking had already been done and we were just vocalising and finalising our conclusions as the process was expedient. The plan developed is detailed in Box 10, Box 11, Box 12, and Box 13.

7.5.1 <u>The triage AMHP will listen to concerns, discuss the concerns with the person and relevant others to explore whether an AMHP will consider the persons case further</u>

1. Triage AMHP role
2. Capture information from a variety of sources.
3. Involving other services where appropriate.
4. Active role in exploring alternatives to admission.
5. Consider how to involve the person referred in the decision.
6. Transparency with the person referred, and all others involved about concerns and outcomes.
7. Peer consultation.
8. The level of assessed risk will inform how quickly a decision is required or how much time can be spent exploring options.

Box 10: Implementation plan one

The inclusion of the *triage AMHP* role was something that had already been implemented in the team between workshop three and four. In my position as AMHP Lead, supported by the team, I was able to implement this without further delay. The identification of the *triage AMHP* role had been emerging throughout the AI and so having identified this we wanted to implement it quickly. This aligns with the simultaneity principle where “change occurs the moment we ask a question” (Whitney and Trosten-Bloom 2010, p.55). The other elements of this implementation plan arose from the creation of time afforded by structuring the rota in a way that separated out the *triage AMHP* role. This plan represents the enactment of the positive core not just when AMHPs have the time to achieve such a high standard of practice, but every time.

7.5.2 All involved professionals will be invited to contribute to a plan with clear agreed outcomes and actions

1. Identify who needs to be involved in the decision.
2. Promote a dialogue with those involved, including the possibility of convening a meeting.
3. Strive toward a shared understanding of outcomes, with clarity about risks and harm.
4. Develop a realistic action plan with shared responsibilities and timescales, with agreed review points. Any resource requirements to be escalated to team managers.

Box 11: Implementation plan two

This implementation plan enacts the collective dream of a *blue light* meeting, accepting that participants would be unable to insist upon the co-operation of other services and so reflecting only what is in the AMHPs control to achieve. This implementation plan is enhanced through the enactment of the first implementation plan, the creation of the *triage AMHP* role.

7.5.3 Work is allocated following a principle of continuity, either where the worker knows the person best or they have relevant expertise with the issues faced by the person referred

1. Identify who in the team, available within the appropriate timescale, knows the person best.
2. Who in the team available has relevant experience, expertise or confidence.
3. If it's possible for one AMHP to follow a situation through this would be preferable, but where that AMHP is unavailable and needs to hand over to another AMHP they will ensure all relevant information is documented clearly to inform future decisions, notifying the person/team on the following day by phone and/or email.

Box 12: Implementation plan three

This plan had been implemented alongside the introduction of the *triage AMHP* role. A new report was developed to capture any actions carried out by the *triage AMHP*, including any thoughts on what should happen next. This report, termed the *AMHP s 13.1 report,* was in response to the acknowledgement of the importance of the decision at the point of referral for an MHA assessment (this decision being incorporated in s 13(1) MHA 1983). The report was implemented in advance of developing this plan because the need for it had become clear as the study evolved. This is another validation of the approach adopted in this study, where practice naturally evolved as new insights were illuminated and the direction of practice development became clear, the essence of the simultaneity principle (Whitney and Trosten-Bloom 2010) and a philosophical position of pragmatism.

7.5.4 We have leadership roles with other services to work positively with them on an ongoing basis, so they understand our role

1. Day to day, communication with other teams is proactive, encourages earlier AMHP involvement, and builds understanding about the process toward an assessment.
2. Develop regular AMHP interface meetings with relevant agencies invited to bring reflections about what's working and what could work better between services.
3. Involve other agencies in the monthly AMHP meetings.
4. AMHPs will participate in all relevant strategic and case meetings where we are notified about them, and informal discussions.

Box 13: Implementation plan four

The first point in this plan was included but there was a sense AMHPs were doing this already. The other points were seen as additional and would act as a way to make day to day communication less confrontational. Point two was borrowed from another part of the service where the council's legal team offer regular legal surgeries open to anyone who wants to attend to ask questions. This concept was expanded to be more collaborative, not positioning the AMHP as the expert but keeping the meeting open to working through current issues in a balanced way. The feeling among participants was that with circumstances that were becoming contentious such a forum would be more productive than the day to day discussions as the meeting would be one step removed from the situation itself, serving more as a reflective space for mutual learning.

7.5.5 Conclusion of the 4-D cycle

At this stage the 4-D cycle was now complete. An action plan had been developed to enact the positive core and collective dream, and some of this plan had already been implemented, specifically the introduction of the *triage AMHP* role and the development of the *AMHP s 13.1 report,* a new report where decisions at the point of referral for an MHA assessment could be recorded clearly when an assessment is not yet completed, the intention being to enhance clarity and continuity where enquiries span a number of days. Other aspects of the plan still needed implementation, but the planning had all been achieved at this point. A legacy meeting was arranged to reflect on the impact of the AI on practice. This aligned with the cyclical nature of AI, where the process is ever evolving as opposed to static and therefore specifically complete at any given point (Reed 2007).

7.6 Legacy

At the end of the final workshop participants agreed to meet three months later to review progress toward the implementation plan and to reflect on their practice following the AI. This meeting again took place online. All but one participant attended. Frank and Ro both commented on a sense of increased confidence in dealing with referrals for assessments since the AI, with Frank adding this was timely given the increased isolation from the team due to colleagues often working from home because of changes in working practices arising from the pandemic. Adding to this Jake reflected that the remote working model enhanced the opportunities for wider consultation as meetings were easier to convene online.

7.6.1 Triage

Rhoda, Charlie, John, and Frank all commented on how the *triage AMHP* role had increased the number of joint visits as part of making decisions about assessment, and that this had become more accepted by some other teams. The definition of the role had therefore afforded AMHPs the opportunity to enact the positive core more often, and in so doing understanding from other services followed. The service may have appeared to offer a more consistent approach to referrals rather than an ad hoc response based on the available time.

7.6.2 Sharing decisions

Rhoda, Charlie, and Frank felt that meetings between professionals to consider options had become more routine, similarly with this becoming accepted and even expected by some other services. Participants had started to suggest meetings rather than there being any service level agreement for this approach to be adopted, an example of how practice can move in a positive direction if practitioners collectively adopt a similar approach.

7.6.3 Continuity

Having moved into a full-time AMHP role Rhoda reflected that this seemed to be working well. Full-time AMHPs were working a three-day week (longer days) and Rhoda commented that this meant it was possible to follow things through. Equally she reflected a willingness to be flexible, sometimes coming to work on a day she wouldn't normally work to finish something she had started. Others felt the *AMHP s 13.1 report* helped with clarifying where one AMHP had got to in terms of decision-making, making it easier for another AMHP to pick up where they left off.

7.6.4 Education

Frank, Rhoda, and John felt other services were starting to understand the AMHP role better, particularly when joint visits were being made with these services. Still a work in progress, but moving in the right direction.

7.7 Second legacy meeting

A further meeting was convened six months later and four participants attended. One valuable aspect identified from the study was the identification of the positive core. It was felt practice had shifted *like osmosis* (Jake) and so participants didn't feel like they were

having to specifically think about enacting their collective dream, it had become their routine practice in response to a referral for an MHA assessment. This was supported by the introduction of the *triage AMHP* role, and participants highlighted that joint visits to the person referred and meetings with other teams had become more frequent. These observations are the clearest validation of this study, there being a sense practice had become more consistently a representation of the ideal as defined by participants.

Rhoda again felt continuity had been enhanced through her working pattern of being on duty on consecutive days. Others contributing on a rota basis felt continuity had not been achieved in the same way for them, but they did feel continuity had been enhanced through better recording using the *AMHP s 13.1 report*. The purpose of the report was for an AMHP, considering a situation under s 13(1) MHA 1983 but not being able to complete their assessment, to have somewhere to clearly record their actions and decision-making. This was considered helpful by participants where situations evolved over several days as it was easier to pick up from where the last AMHP left off. This was part of the implementation plan for continuity and so it is positive this aspect of the plan had achieved what had been hoped.

There was a sense that further legacy meetings would be unnecessary, the aspects of the plan that participants most wanted to implement had been implemented and practice was evolving in the desired direction, among AMHPs but also among other services.

Chapter 8 Discussion

The purpose of this chapter is to discuss how the results from this study help us to understand AMHP practice at the point of referral for an MHA assessment, and to consider how this understanding may have implications for services and for future practice. The original aims for this study were as follows:

1. To illuminate AMHP decision-making at the point of referral for an MHA assessment.
2. To generate knowledge and understanding of AMHP decision-making at the point of referral for an MHA assessment.
3. To offer AMHPs an opportunity to make use of this new knowledge and understanding in a way that is meaningful for their practice.

By considering their practice now, and defining the aspects of practice that are most valued, participants were able to use that understanding to clarify and validate their practice for the future. As such all aims were achieved in the first stage of this AI, the discovery phase. These aims were achieved through a positive lens by focussing on the best of practice. Through the dream, design, and destiny phases, participants were able to consider practical ways to make the achievement of their practice ideal a consistent reality, further achieving aim three. In social constructionist terms we “created worlds of our own making” (Schön 1987, p.36), then drawing from pragmatism and framed with optimism (Koopman 2006), we enhanced our best for the future. What follows is a discussion about the new knowledge generated and the resulting implications for services and practice.

This qualitative study is the only empirical data currently focussed on this neglected area of practice, and the rich understanding generated provides the first narrative from which other studies may build. It is my intention with this chapter to systematically address the contribution to knowledge from this AI. I started this study with an interest in how this research process might be beneficial for practice, so I will then consider the implications for practice that arise from this new knowledge.

8.1 The process from referral to assessment

I began this thesis with an acknowledgement that both the referral for an MHA assessment and the assessment itself are nebulous. There is no definition in law or statutory guidance about either concept, yet in practice there is a socially constructed reality that enables those professionals involved in the process to enact mental health law in England and Wales.

Broadly speaking a ‘referral’ is construed in practice as some form of communication with an AMHP from another party, usually another professional or a family member, where a request is made to the AMHP for an assessment to be considered. This understanding of the point of referral is underpinned in law in s 13 (1) MHA 1983 whereby an AMHP must “consider the patients case” where they have “reason to think that an application… may need to be made”. The ‘assessment’ is then considered to be the coming together of the AMHP, two doctors as defined in s 12 MHA 1983, and the person referred for an “interview” (s 13(2) MHA 1983). This interview is an AMHP responsibility, with doctors being required to have “personally examined” (s 12(1) MHA 1983) the patient, but the merging of these legal responsibilities in the assessment interview has occurred in practice. What happens between the ‘referral’ and what I will henceforth refer to as the ‘assessment with doctors’ is rarely mentioned in research, and there is no statutory guidance issued to AMHPs about how to navigate this mysterious terrain.

As an AMHP this area of practice has fascinated me, not least because of the paucity of information in relation to how individual AMHPs approach it. To be provocative, I was not taught how to respond to a referral when I trained as an ASW; I have never since received any formal or structured guidance on how to approach this; and if I base my practice on the available research on the matter I would conclude that there is little to be interested in here: a ‘referral’ for an MHA assessment leads to an ‘assessment’ between the AMHP, two doctors, and the person referred. Yet most AMHPs in practice will be familiar with a process between the referral and the assessment with doctors, albeit ill defined.

Some services have sought to provide localised processes, often targeting the notion of a ‘referral’ and setting principles that promote a judgement about whether a referral should be ‘accepted’ or not, introducing the concept of screening. Referrals that are ‘accepted’ lead to an assessment with doctors, while those ‘not accepted’ are returned to the referrer and no active decision has been made (Quirk et al. 2003; Brammer 2020; Wickersham et al. 2020). Wickersham et al. (2020) carried out a mixed methods study in inner-London, combining the review of risk decisions at MHA assessments in recording systems with semi-structured interviews with AMHPs and doctors involved in those assessments, then a focus group with NHS Trust managers. In their study this screening process helped reduce detentions (Wickersham et al. 2020).

Referrals that are ‘accepted’ but still pending an assessment with doctors can sometimes be ‘cancelled’ when circumstances change before the assessment with doctors takes place

(Quirk 2007; Brammer 2020; Wickersham et al. 2020). Such processes indirectly address decision-making at the point of referral for an MHA assessment, but seek to reduce these decisions to simple variables, and situate them outside of an assessment process and the MHA 1983 itself. As such they lack definition and are of only limited benefit to individual AMHPs. This AI has highlighted this reductionist approach as insufficient to explain the decision-making process followed by the AMHPs in this study when they are practising at their best.

I have detailed in my introduction why I think decision-making at the point of referral for an MHA assessment is important, mainly relating to how the assessment with doctors can be traumatic (Brammer 2020; Rooke 2020; Blakley et al. 2022), experienced as procedural (Grace 2015), and often the very triggering event that makes detention necessary (Matthews 2015). Indeed, the result of assessments with doctors is usually detention (Wickersham et al. 2020; Davidson et al. 2021).

AMHP services are structured in a way that relies upon the swift transition from referral to assessment with doctors (or screening away from an assessment) because AMHP duty systems often rely on workflow that can be started and completed by the same AMHP, usually the same day. Work that is considered an assessment is prioritised, adopting the earlier interpretation of an assessment with doctors. There will be exceptions to this statement, but my supposition will be instantly recognisable as representative by professionals in the field. Indeed, Abbott (2022) and Fish (2022) both found assessments were completed on the same day as the referral. Abbott's (2022) paper is a publication emerging from his doctoral thesis (Abbott 2018) providing an additional layer of analysis of his findings. Fish's (2022) paper is an opinion piece about the social perspective in AMHP practice and the MHA 1983.

Wickersham et al. (2020) found a desire for swift assessment with doctors following referral, an opinion advanced by a doctor in their study as a contributing factor to avoiding detention. This view was supported by other participants, albeit the context of their agreement was the negative impact of operational delays once an assessment had been agreed as necessary, contributing to further deterioration before assessment. The latter point is superficially consistent with the former, but Wickersham et al. (2020) also highlighted "rigorous referral screening" (p.655) identified by AMHPs as supporting lower rates of detention. As such there is an acknowledgment that decisions at the point of referral can be crucial, and while the doctor's recommendation for swift transition to

assessment seemed superficially supported, this only related to those situations AMHPs had already agreed required an assessment rather than all referrals.

8.2 A new conceptualisation

This study has encouraged a new conceptualisation of what is meant by an assessment. An imperative to assess with doctors based on pressures and service structures, and the likelihood of detention upon assessment (Wickersham et al. 2020; Davidson et al. 2021), highlights a coercive process that doesn't align with the principle of least restriction and maximising independence (DoH 2015, chapter 1.1), suggesting a possible disparity between the context of the referral, and the AMHP role.

This study has provided rich detail about the way in which AMHPs in this study strive to approach their practice at the point of referral for an MHA assessment. The concept of assessment is extended in this study as a process of information gathering, multi-agency working, and inclusion of the person referred and their family *without* the traditional assessment interview with an AMHP and two doctors. This s 13(1) MHA 1983 decision-making process is an assessment in itself, with AMHPs only involving doctors in an assessment if this process has exhausted all options and detention has become the only viable outcome in the AMHPs opinion. The detention decision itself is relocated to this earlier stage where following referral, AMHPs will complete an assessment to conclude that either detention appears to be the only viable outcome or it can be avoided, further drawing attention to a greater sense of optimism about decisions at this stage.

Participants in this study did not frame their practice explicitly in this way, rather 'assessment' tended to be the term applied to assessing with doctors, with the process in advance of that remaining ill-defined, but on further analysis the process of decision-making described is inherently one of an assessment in itself, and a decision to involve doctors was only made once detention was considered necessary by the AMHP. This is not to dismiss the potential of not detaining the person following an assessment with doctors, but the previously cited escalation caused by the assessment process makes avoiding detention harder than the more collaborative assessment that can be achieved at the point of referral for an MHA assessment.

Forming an opinion about detention at the point of referral was partially supported by Brammer (2020), who conducted semi-structured interviews with eighteen AMHPs based around a vignette case study, followed by a focus group with seven different AMHPs where

the topic of discussion was whether a mental health law was necessary. In his study, Brammer (2020) found that AMHPs made a decision at the point of referral about whether they thought the person would meet the grounds for detention, prior to proceeding with an assessment. By this Brammer (2020) was referring to the grounds for medical recommendations for either s 2 or s 3 MHA 1983, which may be broadly conceptualised as the internationally familiar mental disorder and risk criteria (Davidson et al. 2016a). Much like participants in this AI, the assessment at the point of referral for an MHA assessment was conceptualised as something different to a 'full assessment' (with doctors) (Brammer 2020). In Brammer (2020) the decision made by AMHPs at the point of referral was around the likelihood the criteria for detention would be met, whereas in this AI a much clearer view about detention was sought prior to involving doctors in an assessment interview.

There may be many examples where the transition from referral to assessment with doctors is imperceptible (Abbott 2022; Fish 2022), but when prompted to explore the best of their practice, AMHPs in this study identified situations where a more thorough assessment is conducted in advance of convening with doctors. This has created a new socially constructed practice reality, divergent from the prevailing narrative, emphasising the importance of an assessment process informing decision-making at the point of referral for an MHA assessment, and crucially situating this *within* the MHA 1983 via s 13(1).

The AI methodology adopted in this study promoted aspirational thinking, but those aspirations were firmly rooted in examples from the best of practice achieved by participants. These examples emerged through the generative nature of conversation (Bushe 2001), supporting a socially constructed reality of practice. This new narrative led to pragmatic service developments, highlighting the relevance of practice-based evidence for practitioners (Marsh and Fisher 2005). This study defined a reality of practice at the point of referral for an MHA assessment, one that participants achieved some of the time and wanted to achieve more. Within the service, when an AMHP receives a referral for an MHA assessment they strive to conduct an assessment at this point, seeking to reach a decision about whether detention is required, and this is carried out within the legal framework provided by s 13(1) MHA 1983. The aim of this assessment at the point of referral for an MHA assessment is to try to avoid detention. Through the legacy meetings it was clear the best of practice was replicated with greater frequency, this becoming the new norm for AMHPs in the service.

8.3 Changing gears and buying time

AMHPs in this AI have advocated for a more inclusive and collaborative pathway to assessment with doctors, that shares complexity and explores alternatives to detention, encapsulated in the metaphor *changing gears and buying time*. The point at which a professional contacts an AMHP to discuss a referral is fraught with tension (Abbott 2018; Rooke 2020). Based on my literature review this tension appears to relate to risk and accountability (Sheppard 1990; Peay 2003; Skinner 2006; Kinney 2009; Glover-Thomas 2011; O'Hare et al. 2013; Fistein et al. 2016; Stone 2017), albeit acknowledging risk decisions are highly subjective (Sheppard 1990; Peay 2003; Stone 2017). An inclusive and collaborative pathway is one way this study has addressed these practice issues.

This study has found the first consideration of the AMHP is to influence the way in which the situation is being viewed through an analysis of risk, drawing upon their experience, with the goal of lowering the perception of risk and therefore slowing the pace toward detention. This was conceptualised by Kinney (2009), who proposed in his opinion piece that the 'risk criteria' for detention should be the focus for the AMHP, as this is where they are likely to be able to influence outcomes. Brammer (2020) supported this empirically, identifying that AMHPs deconstruct risk narratives and have a higher tolerance for risk than other professionals, particularly doctors. A higher risk tolerance at the point of referral based on risk analysis, enables the AMHP to *buy time* to gain a greater understanding of the person and their situation, sometimes building a personal connection with the person referred to facilitate this. Building a personal connection was supported by Rooke (2020) as a way of promoting a less restrictive approach, although Rooke (2020) only considered this possible where risks are low. This AI has shown how AMHPs lower risk perception in the first instance, then draw on the benefits of meeting the person in more situations than envisaged by Rooke (2020). This point deserves emphasis, for this AI saw increased opportunities for an assessment process following referral during this study. This highlights the desire to practise in this way is achievable in many more situations than previously imagined by AMHPs, through a process of risk analysis.

Transparency with the person referred was considered to breed collaboration, and open opportunities for a different path and outcome to be created with the time made available, and with the benefit of the increased understanding and connection with the person

referred, supported by Blakley et al. (2022) as desirable but absent from MHA assessment processes that involve three assessors. AMHPs expressed optimism for an alternative outcome to detention at the point of referral for an MHA assessment, mirroring the optimism borne out of connecting with the person identified by Pooler et al. (2014a).

Wickersham et al. (2020) found support for collaboration with service users in what they termed 'informed decision making', which included involving families and networks, and gathering wider information. These factors were seen as part of early intervention to avoid an outcome of detention, equally described in this way by Rooke (2020). There is a risk in assuming early intervention is required to enact these desires, with this AI suggesting that is not necessarily the case given risk analysis can reduce the perceived acuity of the situation. Indeed the legacy meetings highlighted practice moved further in the desired direction, with many more visits to those referred with professionals from other teams.

Another study into mental health practice found a similar desire to slow down decisions and thus safeguard against reactive practice (Regehr et al. 2022). They carried out a design-based research study seeking to improve professional decision-making in situations of risk and uncertainty. Their research involved social workers, nurses and occupational therapists working in a mental health facility in Canada. The focus of their study was to improve decision-making on an individual level through increased knowledge and greater self-awareness. Thirteen participants took part in a simulated exercise where a real-life scenario involving a person feeling suicidal was enacted. Participants interviewed the person for fifteen minutes while wearing a heart-rate monitor. The activity was recorded, then they watched the scenario back and took part in a structured reflection about their assessment of the risk, their decision-making process, and other influences. Participants then undertook a risk assessment masterclass over four months, comprising four three-hour educational sessions. They kept a professional diary of crisis situations at work and they wore a wrist-based heart-rate monitor so they could record their heart-rate at times of crisis. Fundamentally they validated the significance of emotional reactions to stressful situations on professional decision-making, which led to "selective attention, focussing on threat stimuli" (Regehr et al. 2022, p.1344). In slowing down the process of decision-making participants consciously acknowledged complexity and sought to gather more information (Regehr et al. 2022). Their study highlighted a process of pedagogic practice development, as was their intention from the outset, while in this AI similar observations about practice were recognised by participants through collaborative strengths-based

workshops. Slowing down and analysing information to a greater degree was identified by participants as part of their current best practice. This recognition led on to pragmatic ideas about how to develop practice, including aligning elements of the service with these more clearly recognised goals.

From this AI participants have understood the impact of emotionally driven decision-making and therefore focussed on a more analytical approach. This was achieved by actively analysing those risks to expose weaknesses in the rationale for requiring a quick response. This active process of first level analysis then gave the AMHP the potential to create the time required for a more analytical and collaborative approach. AMHPs in this study began with a desire to find an alternative to detention, then rather than assume responsibility for risks they aspired to share those risks among all appropriate stakeholders, including colleagues, wider professionals, the person referred and their family. Following Regehr et al. (2022) this sharing of responsibility may reduce the acuity of the emotional response and enable the AMHP to highlight the biases arising from a focus on threat stimuli. In a mental health system overly focussed on risk and accountability (DHSC 2018), creating more time to respond to crisis situations may be the first step toward countering this.

Saltiel (2016) equally highlighted the significance of time pressure on social work decision-making. He carried out an observational study of social workers in a child protection setting and noted the tension between a pressure to assess situations quickly, and a desire to gather adequate information to inform the decision. This combined with being overwhelmed and having to prioritise work increased the chance of decision errors.

Together the findings from Saltiel (2016) and Regehr et al. (2022) support the desire to *change gears and buy time* identified in this AI. The desire in this study to create opportunity at the point of referral led to the creation of the *triage AMHP* role, giving the AMHP the time and space to explore referrals fully rather than being distracted by pressure to resolve other work. Together with the creation of a specific report format that would capture the work at this stage of the process, the *AMHP s 13.1 report*, a socially constructed reality of best practice was created for this stage of the process and this was acted on pragmatically and with optimism through service redesign.

Within this narrative, there is a clear indication that AMHPs are approached to consider MHA assessments in a climate of anxiety (Abbott 2018; Rooke 2020). There is recognition

of this in the MHA review where risk aversion is seen as key to rates of detention being too high (DHSC 2018). It has been conceptualised that AMHPs are complicit in such high rates of detention given they are the applicant (Fish 2022). The nature of the methodology adopted in this study which promoted the best of practice highlighted in positive terms what AMHPs in this study were trying to achieve. In dealing with these high-tension situations regularly, AMHPs drew on their experience and support within the team to analyse risk and highlight where they have become overinflated, a finding partially supported by Brammer (2020). The influence of team support on detention decisions has been established (Quirk et al. 2003; Stone 2017). In exposing risk inflation AMHPs in this study achieved a slowing down of the process which enabled them to provide a more considered response, with the ultimate goal of avoiding detention. This suggests that rather than being complicit in high detention rates, AMHPs in this study actively limited detention through an analytical rather than reactive approach when practising at their best.

The establishment of active decision-making at the point of referral for an MHA assessment through a process of assessment, and the creation of the *triage AMHP* role and the *AMHP s 13.1 report,* construct a reality of practice at this stage, relocating the essence of detention decisions to the point of referral, and affording AMHPs the opportunity to avoid detention more successfully than is achieved when assessments are convened with doctors. This recognition, conveyed through the *changing gears and buying time* metaphor, is a central aspect of new knowledge and service design emerging from this AI. These findings offer a significant departure from many AMHP service structures where assessments with doctors are prioritised. They are built on what the AMHPs involved in this study have defined as their best, and as such are meaningful to the practice context in both a socially constructed and a pragmatic sense.

8.4 Buying time to explore alternatives

Collaboration has been introduced above as something which is more achievable in the context of a referral for an MHA assessment if the process is slowed down. Indeed the creation of the *triage AMHP* role further created space for meaningful collaboration in this context. Given collaboration is not reliably achieved in assessments involving three professionals (Blakley et al. 2022), this finding is potentially transformative for those subject to the referral.

Keddell (2011) carried out research into best practice in social work child protection in New Zealand. From the philosophical position of social constructionism she noted that reality is constructed between the social worker, client and organisation. Her participant social workers were non-judgemental and trusting of the parents they worked with, being transparent about risks and working collaboratively with parents to manage these risks. Opportunity arose from hope, and Keddell's (2011) study closely resonates with the findings from this study into AMHP decision-making at the point of referral for an MHA assessment, where hopefulness, transparency, and a personal connection, are key to situated risk constructions and management.

In a mental health context, Nolan and Quinn (2012) researched the approach to risk management by the Scottish Mental Health Officers, which is an equivalent role to the AMHP. Mental health legislation is different in Scotland and so the context may not be entirely comparable, and they were not specifically focussed on risk management in the MHA assessment context, but their study generated some resounding similarities to this AI. In particular they found ubiquitous support for getting to know the person, including them in decision-making, and an assessment of their relevant capacity. Nolan and Quinn (2012) involved seven purposively sampled participants in one local authority area where there was organisational support for an approach that supported positive risk-taking. Our small-scale qualitative studies in different geographical regions with different mental health laws nevertheless share some commonalities in our findings, and support the value of rich data generated about unique contexts (Hughes 2011).

Cui et al. (2021) found that values of empowerment permeated social work practice in Hong Kong and Sydney, validating an emphasis on capacity and relationship-based work, as well as a balance of risks including the potential harm caused by coercive interventions. This is consistent with other literature, such as Davidson et al. (2016b) who argued engagement, relationships and trust are key to working with people in mental distress as opposed to focussing on risk where outcomes cannot be predicted. These are important comparable findings because our studies highlight the context of practice shrouded in risk, yet the practice focus is far more person-centred. This resonates with my literature review, where the dominance of risk belies the influence of morality in ASW/AMHP detention decisions.

This AI has validated how risk can dominate the point of referral for an MHA assessment. However, through the *changing gears* metaphor AMHPs analyse risks to create opportunity

to *buy time*, which in turn enables collaboration with the person and other services to explore alternatives to detention in hospital. Collaboration and a connection with the person contribute further to the risk perception supporting a higher tolerance of risk, mitigating against the current culture of risk aversion in mental health services (DHSC 2018). This higher tolerance of risk for known people was supported in relation to detention decisions (Peay 2003; Stone 2017), and Wickersham et al. (2020) further found the presence of a known professional lowered the chances of detention.

There are some critical findings from Abbott (2018) that are developed and exemplified in this AI. In his later paper Abbott (2022) summarised there was an absence of the voice of the person being assessed; the views of others were prioritised; the distress of the person assessed was a decisive influence; a focus on risk at the point of referral; compromised organisation systems that contribute to detention as an outcome; and issues about a lack of trust and feasible alternatives that increase the likelihood of detention. Abbott (2022) asserted that to achieve a human rights-based approach the voice of the person needs to be amplified, but he also acknowledged the assessment is experienced as distressing by those subject to it, with acute distress preventing their views being incorporated (Abbott 2022). This AI has highlighted the greater potential to incorporate the views of the person referred at the point of referral, prior to convening an assessment that includes doctors which may be experienced as distressing in itself. In this way the traditional assessment interview may be viewed as fateful (Abbott 2022) and inherently flawed from a human rights-based perspective, with effective decision-making at the point of referral for an MHA assessment being the way to counter this. Analysing risk, slowing down the process of decision-making, meeting the person referred, and working transparently and collaboratively with them to explore alternatives to detention, are all ways AMHPs in this study addressed the issues advanced by Abbott (2022).

Abbott (2022) highlighted that a focus on risk drives the decision to carry out an assessment in the first instance, which Regehr et al. (2022) found led to defensive decisions in a comparable context. In Abbott's (2018) original study all participants carried out an assessment with doctors on the same day of the referral, with Fish (2022) having expressed an opinion that often detention decisions are made within hours of a referral, and Wickersham et al. (2020) having suggested this is preferable. Participants in this AI have rejected this approach and highlighted the best of their practice was when they were able to analyse risk and reduce the acuity of the perception of risk. In turn they created space to

work more collaboratively with the individual referred, potentially seeing them prior to making a decision about whether to involve doctors in an assessment, and therefore increasing the chances of them being able to participate in a discussion to advance their perspectives in a less distressing context.

Blakley et al. (2022) researched the service user experience of the MHA assessment process and found participants felt they were not listened to and could not contribute meaningfully to the assessment. This innovative study included service user researchers and was therefore collaborative in design and execution. Ten participants were interviewed using questions designed by service users to elicit subjective narratives about their experiences. Blakley et al. (2022) advocated for greater service user involvement in the assessment process, including increased transparency about options. It is encouraging that a study collaborating with those with lived experience of the assessment process has highlighted such similar ideals to this AI involving AMHPs, suggesting AMHPs in this study have been attuned to the wishes of those assessed. Abendstern et al. (2021) found social workers in mental health teams felt they displayed a deep level of empathy with service users through tacit communication and relational skills, a finding supported by the combination of this AI with those from Blakley et al. (2022). Abendstern et al. (2021) thematically analysed data from focus groups with mental health social workers and their multidisciplinary colleagues.

Amplifying the voice of the person referred to achieve a human rights-based approach appears an achievable aim when AMHPs work collaboratively with those referred in advance or instead of convening an assessment with doctors. The goal to achieve this through *changing gears and buying time*, while representing the best of practice, was not aspirational; rather the workshops were replete with examples from participants where this had been achieved, and this practice was commonplace enough to epitomise the best of AMHP practice. The legacy meetings supported that examples of achieving this aim increased with the introduction of the *triage AMHP* role, highlighting further how these aims were realistic, and supporting the coherence of pragmatism as a philosophical position.

This AI has focussed on the participants' definition of the best of their practice, and within this there may be acknowledgement that the best of their practice was not always achieved. This is the inevitable shadow created by such a focus (Fitzgerald et al. 2010), but rather than dwell on problems participants addressed some of the organisational

challenges to achieving their goals through the development and implementation of service design elements. Abbott (2022) emphasised the influence of organisational systems that drive detention decisions, and participants in this study have grasped this and created systems that enhance their ability to achieve the best of their practice more of the time. Valuing the point of referral by creating a bespoke *triage AMHP* role and *AMHP s 13.1 report,* allowing AMHPs the opportunity to fully explore a referral situation in the time created through risk analysis, was crucial to AMHPs achieving best practice in this study, and arguably goes a long way to meeting the challenges for practice identified by Abbott (2022) and Blakley et al. (2022). Together with a pathway to assessment with doctors, these findings represent the core contribution to knowledge from this AI into a formerly neglected area of practice in research and statutory guidance.

8.5 An inherently social role

With collaborative working comes a natural affinity with social work as a profession. While the AMHP role may be performed by other professionals, including mental health and learning disability nurses, occupational therapists, and chartered psychologists, most AMHPs remain social workers (Skills for Care 2022). The values imbued in social work as a relational role where rights, transparency, inclusion and equality are paramount (SWE 2019) mirror exactly what AMHPs in this study have defined as the best of their practice. Broadening the ASW role to other professions meant the removal of social work from the title, recognising it as protected (Care Standards Act 2000). The intention was to reflect multi-disciplinary working but retain a social focus through ongoing social work regulation (DoH 2008b). This was not clearly reflected in the explanatory notes to the MHA 2007 which referred to a “mix of professional perspectives” (para 64), but the MHA Code of Practice published in 2008 supported retaining a social perspective (DoH 2008a, chapter 4.51). Social work holds no monopoly over such a focus, but removing the requirement to be a *registered* social worker to become an AMHP did not simultaneously remove the essence of *social work* from the role. There were eight social workers and one nurse participant involved in this AI. Vicary (2017) identified the AMHP role influenced professional identity, rather than the other way around, and that often nurse AMHPs were viewed as “honorary social workers” (Vicary 2017, p.177). This AI also highlighted a shared reality constructed across professional groups.

Banks (2010) highlighted how social workers bring their personal values into their profession, measuring their success by how far they achieve the enactment of those values.

Dixon (2010) introduced the notion of virtue ethics to mental health social work practice, in particular risk assessment. Chamiec-Case (2013) described virtues as deeply held character traits, such as honesty and compassion for example, that underpin practice and may be value-driven, such as a focus on strengths. Interpreting AMHP decision-making at the point of referral for an MHA assessment through the lens of virtue ethics, virtues may override actuarial risk assessments to contribute to a higher threshold of risk. The notion of virtues as deeply held character traits that underpin practice resonates with the morality theme in my literature review, where the personal and professional domains converge. In their study into joy in social work, Pooler et al. (2014a) and Pooler et al. (2014b) identified a strong connection between the personal and professional domains in social work, with participants reporting a sense of personal growth and meaning derived from their practice. Wiles and Vicary (2019) researched social work identity across Europe, asking social work participants to work together in groups using rich pictures to express meaning. One theme of professional identity was passion, symbolising the personal domain within the professional role. Again social work was not considered to be the only profession where passion could be displayed, but for social work passion was considered necessary for successful practice (Wiles and Vicary 2019). England (1986) viewed social work as art and an enhanced form of common sense. Common between these perspectives is the notion that key social work attributes are not restricted to social work, but they are nevertheless essential components of social work. The AMHP role appears to inhabit this space, where social work attributes are essential even when social work registration is not. Enacting the AMHP role, including decision-making at the point of referral for an MHA assessment, may therefore involve a process of enacting social work, registered or not.

8.6 New knowledge and implications for practice

This AI into AMHP decision-making at the point of referral for an MHA assessment has uncovered some aspects of practice previously hidden, and as such new knowledge has emerged. Some pragmatic implications for practice have arisen from this new knowledge.

8.6.1 An emphasis on the s 13(1) assessment

This AI has drawn attention to how AMHPs explore a myriad of issues prior to convening an assessment with doctors when they are practising at their best. Traditionally, an MHA assessment is considered to involve two doctors and an AMHP, although this is not defined in law or practice guidance. The requirement to involve doctors in MHA processes, is to

provide the necessary medical opinion and recommendations upon which an application for detention may be founded (s 12(2) MHA 1983). Yet the AMHP role is to explore the social perspective, applying the principle of least restriction and considering alternative options (DoH 2015, chapter 14.52). Blakley et al. (2022) have highlighted how this is not achieved in MHA assessment processes where all three professionals are present, leaving those subject to the assessment feeling peripheral to the decision and disempowered.

The divergence from traditionally accepted assessment processes identified in this AI, emphasises the importance of the AMHP role at the point of referral for an MHA assessment, for it is at this point AMHPs in this study have identified they are more able to achieve the intention of their role than at any other time. The importance of this is highlighted by some studies that have found detention is the most likely outcome of assessments convened with doctors (Wickersham et al. 2020; Davidson et al. 2021).

Extending the notion of screening referrals mentioned by Wickersham et al. (2020), developing a collaborative and transparent approach to an assessment and decision-making process at the point of referral supports the practice ideals advanced by Blakley et al. (2022) and Abbott (2022). This is the enactment of s 13(1) MHA 1983 in its richest sense, where the AMHP is tasked to “consider the patient’s case” and from this study does so thoroughly and inclusively prior to reaching any conclusions about involving doctors in a more oppressive assessment process destined for a detention decision. This represents an assessment in itself, and the trajectory toward detention has scope to be diverted at this point. The *triage AMHP* role and *AMHP s 13.1 report* were developed as part of this AI to recognise that such assessment activity requires the investment of time that might be lost on traditional assessment approaches without such a safeguard.

This finding is significant for two reasons: firstly, the detention decision is located in the assessment completed by the AMHP, prior to making a decision about involving doctors in an assessment interview; and secondly, it locates this assessment within the MHA 1983 itself, rather than considering it a passive decision, based on simplified variables, that takes place outside a statutory context, as is the case with notions of referral screening.

The significance of the assessment at the point of referral, presents both challenges and opportunities for AMHP services: it can be difficult to prioritise work that is not the traditionally accepted MHA assessment with doctors, but to do so may lead to less assessments with doctors and therefore less detentions.

8.6.1.1 S 13(1) is the detention decision

One shadow created by the best of AMHP practice at the point of referral for an MHA assessment, is that the traditional MHA assessment interview with doctors is implied as being flawed, destined to result in the detention of the person (Wickersham et al. 2020; Davidson et al. 2021). Blakley et al. (2022) called for improvements to the assessment process, a suggestion with much merit, but this AI has focussed on assessments at the point of referral, prior to involving doctors in an assessment interview. Any decision made by an AMHP to proceed with an assessment with doctors, in this study, became by default a decision to detain the person, subject to the required medical recommendations. This finding offers one explanation for my interest in this topic: the complexity of the decision is founded upon the difficulty of achieving best AMHP practice in the MHA assessment with doctors. There will be circumstances where the assessment with doctors leads to an outcome that is not detention, but these are the minority.

The implication from this study is that, prior to organising an assessment that includes doctors, AMHPs should ensure that they have satisfied themselves that detention is required. Brammer (2020) found something similar in that AMHPs wanted to establish an opinion about whether the person met the grounds for detention prior to involving doctors, however this was more about the potential rather than forming a definitive opinion based on an assessment of the person. AMHPs in this study have described an intricate process of assessment they follow to reach such a conclusion, when they are practising at their best. The sense of optimism about avoiding detention through their intervention at this stage, stands in stark contrast to the lack of optimism about the outcomes following an assessment with doctors (Bonnet and Moran 2020). Bonnet and Moran (2020) sought to understand AMHP perspectives on why detentions are rising in the context of the independent review into the MHA 1983, and the future potential for legislative reform. Key to the research was whether legal reform is the appropriate response to address the high rates of detention. A mixed-methods study design was adopted, combining an online survey of 160 respondents and six semi-structured interviews, subject to framework analysis. The study highlighted an emphasis on creating more alternative resources to avoid detention (Bonnet and Moran 2020), the implication being that service deficits lead to detentions that might otherwise be avoided. AMHPs in this AI, when considering the point of referral, were optimistic about finding alternatives to detention within current resources, a striking difference in perspective.

8.6.1.2 AMHP triage in a statutory context

Conceptualising AMHP decision-making at the point of referral for an MHA assessment as a screening process, where referrals may be rejected based on simplified variables, reduces the process to a non-decision, displacing responsibility for the decision back to the person making the referral, effectively absolving the AMHP from making any decision. The AMHP has simply identified something the referrer must do before their request can be considered. This has previously been conceptualised as a non-legal or informal process (Quirk et al. 2003; Quirk 2007; Glover-Thomas 2011; Brammer 2020), reduced from assessment to screening (Wickersham et al. 2020). Rooke (2020) sought to counter this in her opinion piece, situating a visit to the person referred within s 115 MHA 1983, a power invested in an AMHP to enter someone's home where there are concerns about their mental health and welfare. She also described this visit as part of s 13(1) MHA 1983, but only in an early intervention context where risks are assessed as low (Rooke 2020). This AI has firmly situated the assessment at the point of referral for an MHA assessment within s 13(1) MHA 1983, much like Rooke (2020), although applied more broadly to all referrals not just those made as part of an early intervention strategy. Such an approach makes both the assessment and the decision a statutory one. AMHPs in this study wanted to invest in referrals, sharing decisions with those referring and seeking alternatives collaboratively. AMHPs were seen as having unique skills in this area that are not easily devolved to other professionals. This represents an ethos of working together to prevent detention, which stands in contrast to notions of referral screening. This AI has defined a socially constructed reality of AMHP practice that, when working at their best, AMHPs receive referrals for MHA assessments; they complete a process of assessment at that stage under the MHA 1983; and they only involve doctors in an assessment interview if they conclude detention is necessary.

8.6.1.3 Positive change

This research was conducted appreciatively and collaboratively, resulting in pragmatic service design changes that enhanced the best of practice, as defined by the AMHPs involved in the study. Identifying the best of practice was achieved through the sharing of positive stories, and then analysing those stories to understand what best practice looked like, and how it could be replicated. A socially constructed reality of best practice was created, with tangible actions following to embed the best into the day-to-day. This epitomises practice-based research, merging research and practice meaningfully for mutual

benefit: the research methods facilitated a process of practice development arising from practice wisdom, and the creation of a shared understanding. The outcomes arising from the new knowledge generated have been directly applied in practice, pragmatically legitimising the research activity for practitioners, and enhancing rigour (Porter 2007).

Implications for practice

The AMHP decision at the point of referral for an MHA assessment is a statutory decision under s 13(1) MHA 1983. This is more than referral screening: it is an assessment in itself.

The likelihood of detention when assessing with doctors relocates the AMHP detention decision to the point of referral. A decision to arrange an assessment that includes doctors requires the AMHP to have concluded that detention is necessary.

Participants in this study created the *triage AMHP* role within the service, together with the *AMHP s 13.1 report,* to capture the assessment process within organisational systems, and to safeguard decision-making at the point of referral for an MHA assessment. This model of service delivery diverges from AMHP service structures that prioritise assessments with doctors.

AMHPs in this study have embraced a sense of optimism at the point of referral, working collaboratively with the person referred and other services in a way that is more consistent with their values, and the goals envisaged for their role. This potentially involves AMHP services having more active involvement in referrals that might otherwise have been screened as inappropriate.

Box 14: The nature of AMHP triage

8.6.2 The active influence on risk perception

A core aspect of the AMHP role is to affect a human rights-based approach in their practice (Abbott 2022), enacting a social perspective and considering alternative options to detention (DoH 2015, chapter 14.52). AMHPs in this AI have highlighted the possibilities for achieving this at the point of referral for an MHA assessment, enabled by an analysis of risk. Risk was evinced by Kinney (2009) as key to the AMHP role, and in this AI risk factors are critically analysed by the AMHP at the point of referral for an MHA assessment, with the harms of admission included in the balance. Brammer (2020) equally supported this finding. Additionally, AMHPs have a higher threshold for risk, promoting positive risks to achieve collaborative aims. Risk was identified as critical in detention decisions (Sheppard 1990; Glover-Thomas 2011; Stone 2017; Brammer 2020; Karban et al. 2021) and the point of referral for an MHA assessment represents a crisis where risk factors have become

intolerable for the referrer (Abbott 2022). Thompson (2003) considered the crisis as a turning point where things can either get worse or get better, and Blakley et al. (2022) have highlighted how in an MHA assessment it is usually the former. Achieving their core function at the point of referral for an MHA assessment is a significant finding in relation to AMHP practice, as it raises the importance of this neglected area of practice, situating the key to successful AMHP practice in s 13(1) MHA 1983 decision-making. This is a striking finding given the paucity of attention paid to this aspect of AMHP practice in both research and guidance, and given many AMHP services have not created systems that adequately reflect the value of this decision.

8.6.2.1 Accountability

AMHPs are solely responsible for their decisions at the point of referral for an MHA assessment (MHA 1983, s 13(1)), and so the reduced impact of accountability is superficially counter-intuitive. One explanation is the desire from AMHPs in this study to share the search for alternatives with other stakeholders; another is the desire to draw support from the team. Significantly however, AMHPs approach referrals with a degree of scepticism toward detention, and a sense that there must be some other less restrictive option available. This is contrary to the literature relating to accountability which is closely aligned with risk in detention decisions (Peay 2003; Skinner 2006; Kinney 2009; Gregor 2010; O'Hare et al. 2013; Fistein et al. 2016). The merging of accountability and risk provides some rationale for the likelihood of detention when two doctors and an AMHP convene with a person for what has been called an MHA assessment (Wickersham et al. 2020; Davidson et al. 2021), and contributes further to explaining the reduced impact of accountability found in this study. My practice experience suggests the ability to superficially resolve a crisis through detention when everything is in place to affect this outcome is compelling, especially when coupled with high expectations from family and other professionals that detention will be the outcome. The high rates of detention following MHA assessments support this (Wickersham et al. 2020; Davidson et al. 2021). Assessors may approach the situation with detention in mind (Peay 2003; Buckland 2016), yet this study has highlighted this is far from the case when AMHPs consider the situation at the point of referral for an MHA assessment, providing further emphasis about the significance of effective decision-making at the point for referral for an MHA assessment.

8.6.2.2 Coercion

Deconstructing risk and creating time to explore alternative options, prior to making a decision about whether to involve doctors to provide medical recommendations, is the first way AMHPs in this AI have countered the impact of coercion. Coercion was identified as influential in detention decisions, both before the assessment (Thompson 1997; Thompson 2003; Skinner 2006; Quirk 2007; Abbott 2018) and during the assessment (Haynes 1990; Kinney 2009). Achieving a human rights-based approach requires the AMHP to effectively manage the toxic combination of risk, accountability, and coercion contributing to detention decisions. This AI has found a higher tolerance for risk helped participants achieve this, together with an appreciation of the referred person's strengths and the potential harm of admission, a finding supported by research relating to coercive interventions (Smith 2001; Davidson et al. 2016b; Morriss 2016a; Cui et al. 2021). This is where the individual morality of the AMHP may play a role as identified in my literature review (Smith 2001; Kinney 2009; Yianni 2009; Dwyer 2012; Buckland 2016; Morriss 2016a; Vicary 2017). AMHPs in this study emphasised their optimism for finding alternatives to detention during their interventions at the point of referral for an MHA assessment, and indeed spoke of gaining clarity about risks. Uncertainty was a sub-theme in my literature review contributing to detention decisions (Peay 2003; Skinner 2006; Buckland 2016; Glover-Thomas 2018) therefore gaining clarity at the point of referral is a significant step toward avoiding detention representing another important finding from this study.

8.6.2.3 Countering risk aversion

AMHPs in this study identified the best of their practice as being able to analyse the identified risk factors which they felt were often overinflated by the referrer. Risk aversion is prevalent in mental health services (DHSC 2018) providing rationale for why Abbott (2022) argued for AMHPs to adopt a rights-based approach. This key emphasis of AMHP practice may enable AMHPs to achieve the aim of their role, identified as the best of their practice. This is achieved through collaboration, transparency, and often a connection with the person referred for a more person-centred decision-making process, connecting with the inherently social aspects of the AMHP role.

8.6.2.4 Morality

AMHPs are motivated by contact with service users and a feeling they can make a difference (Huxley et al. 2005), appreciating their independence and ability to uphold

people's rights (Watson 2016). AMHPs may therefore be attracted to this role based on their deep-rooted virtues (Banks 2010) and passion for their practice (Wiles and Vicary 2019). Passion was evident in this AI through the value placed on the AMHP role at the point of referral for an MHA assessment. There was a sense of liberation in adopting an analytical approach to risk that undermined the impact of risk, accountability, and coercion. The prominence of morality shone through in participant accounts of the best of their practice, emphasised in the positive core map and embracing the importance of decisions made at the point of referral for an MHA assessment.

The AMHP role can be stressful (Huxley et al. 2005; Gregor 2010; Watson 2016), partly due to pressure to make decisions about detention quickly (Gregor 2010). The crucial influence of risk over detention decisions was highlighted in this AI, with risk analysis being the mechanism by which AMHPs are able to *change gears* and *buy time* to explore alternative less restrictive options. This is distinct from reactive practice where decisions are based on perceived risks informed by a biased focus on threats (Regehr et al. 2022). The active shift in focus to the person referred enables AMHPs to work in a way that is consistent with the moral imperatives driving their practice.

Implications for practice

The key to successful AMHP practice is in their s 13(1) decision-making. AMHPs are more likely to be able to practice at their best, when they are able to create time to explore the person's situation more thoroughly and collaboratively following referral, encapsulated in the metaphor *changing gears and buying time*.

AMHPs critically analyse risk, approaching the referral with a degree of scepticism about detention, and hopefulness about finding a less restrictive alternative. The harms of admission are included to balance the risks.

A desire for transparency and collaboration contributes to a higher threshold of risk.

Sharing the search for alternatives with other stakeholders reduces the influence of accountability in decisions.

Box 15: The significance of risk analysis

8.6.3 The benefits of slowing down

Directly following from analysing risk come the benefits of slowing down when it comes to achieving the positive core of the AMHP role. Pictured by participants in this study, the

positive core map conveys a rich tapestry of practice ideals centred around connecting with the person in their world to make meaning. Key are notions of transparency, shared understanding, and a personal connection to enable a two-way process of decision-making. This positive core (repeated in Figure 33) is achieved by AMHPs in this study at the point of referral for an MHA assessment when they are at their best, yet this is far from the reality of practice once two doctors and an AMHP convene with the person for a traditional MHA assessment (Abbott 2022; Blakley et al. 2022).

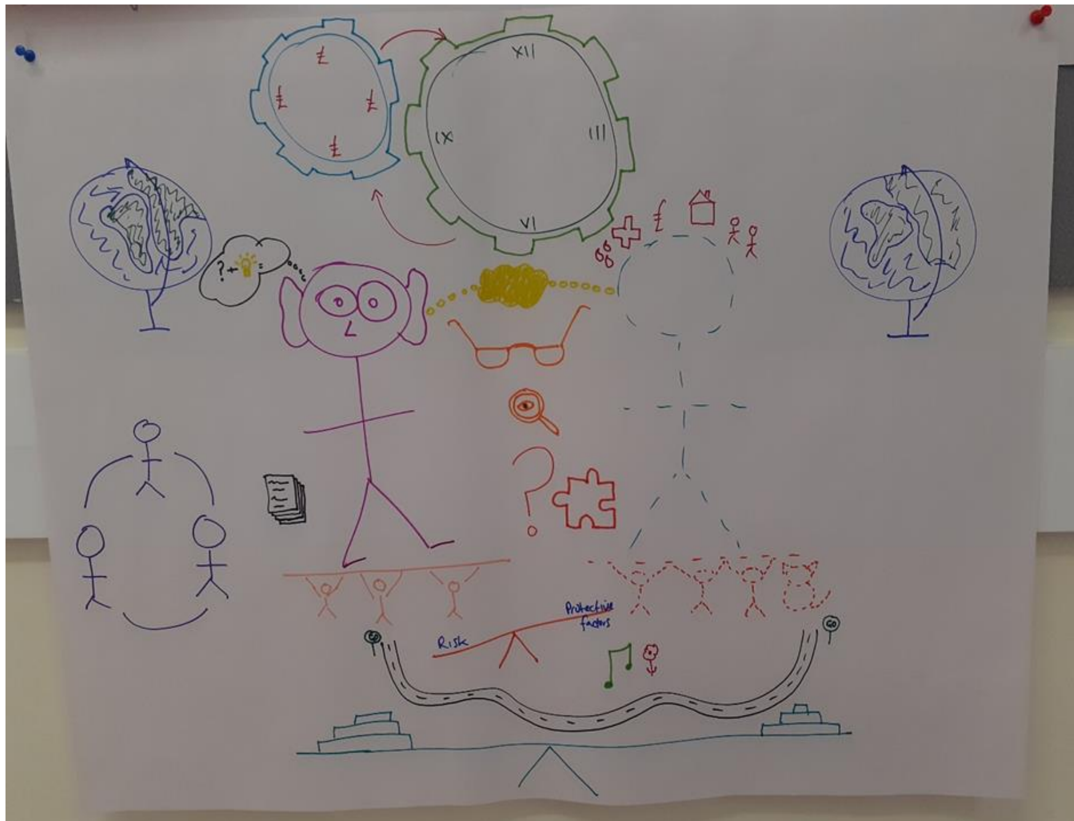

Figure 33: The positive core repeated

8.6.3.1 Clarity

The absence of an understanding of the person referred in the above depiction is striking, with a key aspect of socially constructed AMHP practice being trying to establish clarity through a connection with the person. Clarity was something AMHPs in this study felt they achieved in their assessment at the point of referral for an MHA assessment, in contrast to the literature in relation to detention decisions where uncertainty was a central feature (Peay 2003; Skinner 2006; Glover-Thomas 2011; Buckland 2016). This is a significant aspect of AMHP practice at the point of referral for an MHA assessment that deserves emphasis, with the detention decision essentially relocated to the point of referral, and the richness

achieved in the assessment process gaining clarity that would be beyond grasp once an assessment is convened with doctors.

8.6.3.2 Relationships

In this AI AMHPs demonstrated a pragmatic approach to relationships, identifying the benefits of a connection with the person referred and creating systems to support enacting this example of the best of their practice. Social work as a profession is founded upon relationships (Trevithick 2003), with the AMHP role inhabiting this space irrespective of social work registration, yet there is a tension between relationships and organisational priorities which sometimes prompts more creative approaches beyond organisational processes (Hood et al. 2019). In their qualitative study of relationships in social work, across practice settings, Hood et al. (2019) carried out semi-structured interviews with twenty-five social workers subject to thematic analysis. Identifying system changes in this AI was an overt acknowledgement that service design was not conducive to achieving the best every time, recognising the shadow cast by defining the best of practice (Fitzgerald et al. 2010), but addressing this constructively aligned with the positive principle of AI (Whitney and Trosten-Bloom 2010). The shaping of the service to meet professional priorities aligns the AMHP role with organisational systems, demonstrating the generative nature of the AI process (Bushe 2001). This stands in contrast to problem oriented research methodologies which seek to identify and redress the problems of practice (Dirkx 2006).

Changing gears buys time to gain clarity and work collaboratively with the person and others to explore alternatives. It is striking to consider the organisational systems that may prevent the opportunity for AMHPs to achieve these goals at the point of referral, for Blakley et al. (2022) highlighted how these ideals are not achieved during the assessment when AMHPs are joined by doctors for a traditional assessment interview. The emphasis of time created is to promote a personal connection, work collaboratively and transparently with the person and others, and through this pathway to assessment with doctors create opportunity for a different outcome. This creates a service imperative to create systems that enable AMHPs to dedicate their time to this process of assessment and decision-making at the point of referral for an MHA assessment, where meeting the person referred may form an essential element of achieving less restrictive practice.

8.6.3.3 *Transparency and mental capacity*

Linked to slowing down is the creation of a space for collaboration and transparency, with the person referred and with families and professional stakeholders. This was another important finding in this study. Davidson et al. (2016b) highlighted the central importance of assessing decision-making capacity in mental health social work practice, while Szmukler (2018) emphasised that transparency is integral to informed decision-making. Participants in this AI experienced an absence of this in wider mental health service practice, creating an imperative to incorporate collaboration and transparency into decision-making at the point of referral for an MHA assessment. Blakley et al. (2022) discovered an absence of collaboration and transparency in MHA assessment processes, identifying these factors as highly important to those subject to the assessment. Abbott (2022) acknowledged the MHA assessment interview was distressing for the person being assessed, reducing their meaningful involvement. Collaborative approaches provide opportunities for the co-construction of risk and decision-making in practice, something advocated for in AMHP detention decisions by some authors (Stone 2017; Abbott 2018).

Related to transparency is the consideration of a person's decision-making capacity, and importantly their current and past wishes and feelings. The MHA 1983 does not give decision-making capacity any import in detention decisions. There is statutory guidance that supports considering a person's current and past wishes and feelings (DoH 2015, chapter 13.10) and their capacity to accept or refuse treatment (DoH 2015, chapter 13.21), however the same guidance suggests the threat of detention would invalidate consent (DoH 2015, chapter 14.17). Szmukler (2018) distinguished a threat (which is not founded on truth) from an offer (which is). Providing information about the prospect of detention to people where this is a realistic outcome, helping them to make informed decisions about whether to accept treatment or not, may be preferable to withholding that information (Szmukler 2018). AMHPs in this study identified that people were often unaware of the concerns about them and the considerations surrounding their detention, and this information was considered essential to enable people to make their own choices about their care and treatment. This aligns with the principles enshrined in the MCA 2005, promoting sufficient efforts being made to enable people to make their own decisions (s 1(3)). This finding is contrary to the MHA Code of Practice (DoH 2015, chapter 14.17) highlighting a conflict between practice and statutory guidance that justifies review in light of the coherence of these findings.

8.6.3.4 Personal connection

Transparency about potential outcomes was one aspect in this AI, but importantly AMHPs wanted to understand the person holistically, and co-create responses that might include accepting levels of risk without resorting to detention, in particular acknowledging the potential harm of detention. Recognising the harm of detention was key to providing a counterbalance to an emphasis on the risk of not detaining the person advanced by those making referrals to the service, and so engaging in the reality of those harms for the person referred was achieved through a personal connection. This personal connection was seen to increase risk tolerance in detention decisions, supporting findings from previous studies (Peay 2003; Quirk et al. 2003; Glover-Thomas 2011; Stone 2017). Intuition was a factor in detention decisions (Dwyer 2012; Buckland 2016; Morriss 2016a; Stone 2017) and the impact of a personal connection may relate to notions of embodied knowing. Muzicant and Peled (2018) researched the social work home visit, highlighting the difference between the bureaucratic and sterile professional domain of the office, and the real world of the person's own home which is experienced physically through the body.

> "Within the grime there is cleanliness – something authentic and valuable, which facilitates communication, personal contact and collaboration with clients" (p.836).

This AI supported how a personal connection may aid a greater understanding of the person, creating opportunities for less coercive interventions. Pooler et al. (2014a) identified relationships as of central importance for the enjoyment of social work, often representing the very motivation for becoming a social worker. Grace (2015) reflected on the procedural nature of the MHA assessment process, later supported by Blakley et al. (2022) who found an absence of meaningful relationships through the MHA assessment interview with three professionals. This AI with its focus on strengths has identified how AMHPs have achieved these relational aspects of their role when meeting with people at the point of referral for an MHA assessment. This is likely to significantly impact upon role satisfaction as Pooler et al. (2014b) earlier identified with the experience of joy in social work promoted by positive narratives despite the challenges of the role. Enabling AMHPs to work in a way that promotes a personal connection with those referred is likely to promote retention in the AMHP workforce through improved outcomes.

Vicary (2017) identified notions of personhood employed by AMHPs while enacting their role. She defined this as applying a moral lens to understanding the person, positively

biased, and leading to protective actions (Vicary 2017). Merged with personhood in her study is the notion of praxis, the embodiment of personhood into AMHP practice, with personhood becoming more than an element of practice, but a defining feature of the role (Vicary 2017). This interpretation, when combined with Muzicant and Peled (2018), can be applied to the findings from this AI, where a connection with the person was a significant feature of achieving the best of practice at the point of referral for an MHA assessment.

Collaboration with other stakeholders including family and services served to provide opportunity for exploring alternatives to detention, while reducing the negative influence of accountability on decision-making by sharing responsibility across a network, directly related to creating a pathway to assessment with doctors. Such collaboration in this study was viewed in tandem with collaboration with the person referred, and was focussed on seeking less restrictive outcomes. Abbott (2022) found collaboration between the AMHP, the person's family, and professionals led to an "unequal coalition" (p.1370), minimising the voice of the person referred and causing frustration for the AMHP. This may be another example where greater attention to a pathway to assessment with doctors may maximise the opportunity for AMHPs to achieve the best of their practice by bringing the persons voice into the decision-making.

8.6.3.5 A pathway to assessment with doctors

The notion of a pathway to assessment with doctors may diffuse the pressure and expectation of detention, valuing the significance of the decision on the basis that assessments often lead to detention (Wickersham et al. 2020; Davidson et al. 2021). There was a sense in this study that detaining someone under the MHA 1983 was a desirable outcome from the perspective of the referrer, and that the process of AMHP decision-making was overlooked, a finding aligned with the perspective advanced by Rooke (2020). AMHPs in this AI wanted to promote robust decision-making at the point of referral for an MHA assessment, aligning MHA 1983 decision-making with child safeguarding procedures under the Children Act 1989, where significant procedural safeguards and transparency define its operation. A pathway to assessment with doctors was therefore seen as a way to strengthen the procedural safeguards within the MHA 1983.

This AI drew inspiration from the transforming care agenda (NHS England 2015) considering a blue light meeting where a range of agencies could explore less restrictive community alternatives. This is already utilised for those with learning disabilities, recognising the need

to ensure hospitals do “not become de facto homes” (Association of Directors of Adult Social Services (ADASS) et al. 2015, p.26). The context of transforming care was the perceived warehousing of people with learning disabilities in private hospitals away from their home area, highlighted in the Winterbourne View inquiry where people with learning disabilities became subject to abuse from those meant to be providing care to them (NHS England 2015). While the context may be different when considering people experiencing mental distress, there are parallel priorities that arguably apply to everyone, namely the provision of support and alternatives in the community to people and their families. Recognition of this is contained within the mental health crisis care concordat (DoH 2014) in which services to prevent admission were promoted as early intervention strategies. This was later reinforced in the NHS long term plan (NHS 2019) , extended from early intervention to alternative options in a crisis. While such options may be explored prior to services contacting an AMHP, the AMHPs in this AI reflected many circumstances where they identified alternatives to detention as part of their decision-making at the point of referral for an MHA assessment. This suggests those preventative options are not being fully explored by mental health services, and AMHPs are being required to explore those options against pressure to detain from mental health services. This potentially places the AMHP in conflict with those seeking an MHA assessment simply because the AMHP is exploring preventative options. This may be due to a sense from those referring that detention is required (Abbott 2018; Rooke 2020). Recognising a pathway to assessment with doctors is one way to redress this issue. In this study, multi-agency meetings became a greater feature of routine practice following referral for an MHA assessment, which may be viewed as consistent with pragmatism.

8.6.3.6 Peer support

Decision-making at the point of referral for an MHA assessment was facilitated in this AI by support from peers and wider professionals. A narrative for responding to these requests was established on a team level, with an expectation of critical examination of the rationale for coercive interventions. This socially constructed reality within the team provided the conditions for AMHPs to achieve the best of their practice, and the less restrictive narrative was sustained through peer support, validating the efforts made by AMHPs to identify rationale that undermined wider service pressure to respond reactively. Team support has been previously identified as helpful (Huxley et al. 2005; Gregor 2010) and likely to reduce the chances of detention (Quirk et al. 2003). The findings from this AI validate the

importance of peer support for achieving the best of decision-making at the point of referral for an MHA assessment. This is a significant consideration for organisations following the onset of the coronavirus pandemic. Many services have moved to online working practices distancing colleagues from each other.

8.6.3.7 Team culture

A team culture that promotes thorough exploration of referrals for MHA assessments, creates the conditions for the best of practice as defined by participants in this study. This was earlier identified by Quirk et al. (2003), where operational norms affected ASW detention decisions. This team culture was created in part by this AI, aligned with the simultaneity principle where as soon as we ask a question we begin to change practice (Whitney and Trosten-Bloom 2010). By focusing on the decision at the point of referral for an MHA assessment, AMHP participants in this study started to reshape their practice aligned with their reflections about examples of the best of their practice. This highlights the importance of services facilitating reflective spaces for AMHPs to consider what aspects of their practice they wish to see flourish. For best practice to be maintained, AMHPs benefit from mechanisms promoting peer support, enabling them to gain from the experience of their colleagues and to validate their own views. Additionally, this study highlights the importance of the decision at the point of referral for an MHA assessment being valued by organisations and sustained through a narrative of least restrictive practice. The high rates of detention (NHS Digital 2021), together with the findings from this study provide the imperative for a shift in focus from assessment with doctors, to effective s 13(1) MHA 1983 decision-making.

Implications for practice

Clarity can be achieved through assessments at the point of referral for an MHA assessment, something less likely when assessing with doctors.

Creating an opportunity to connect with the person referred greatly improves the decision, and enables those referred to contribute to detention decisions, again less likely when assessing with doctors.

Collaboration, transparency, and the co-construction of risks are more achievable in assessments at the point of referral for an MHA assessment.

Creating systems that enable AMHPs to practice in a way that is consistent with their values is likely to increase role satisfaction.

Viewing the referral as a pathway to assessment with doctors diffuses the pressure to detain and enables better decision-making. Multi-agency meetings to explore alternatives as part of this pathway, have proven helpful.

Mechanisms that enable and encourage AMHPs to connect with each other to discuss those referred to the service, will maximise the benefits of creating a shared understanding with colleagues about how to respond to such referrals.

Enabling AMHPs to connect and share the best of their practice creates a positive team culture. If a thorough assessment at the point of referral for an MHA assessment becomes part of that team culture then less restrictive practices are more realistically achieved.

Box 16: The benefits of slowing down

8.7 Summary of practical implications

The key learning for practice from this AI may be depicted visually for a different representation of the findings (see Figure 34). Rather than the pressure at the point of referral (Abbott 2018; Rooke 2020) leading to the triggering of an MHA assessment that involves doctors and likely detention (Wickersham et al. 2020; Davidson et al. 2021), when AMHPs are practising at their best they critically analyse risk. They do this within the context of a higher level of risk tolerance, built upon their experience and validated by their peers. In situations where the result of this analysis is the ability to slow down the process, a pathway to assessment with doctors can be created where AMHPs begin to collaborate with the person referred, their family, and other services. At this point the core aspects of AMHP practice can be achieved where transparency and co-construction can lead to a reality that opens avenues to less restrictive alternatives to detention. This potentially avoids the need to progress to assessing people with doctors, a process likely to raise their distress (Grace 2015), fail to hear their voice (Blakley et al. 2022), and increase the

likelihood of detention (Matthews 2015). AMHPs are able to reconnect with their core personal and professional values emerging from a desire to connect with people (Pooley et al. 2014a; Pooley et al. 2014b) and work relationally (Trevithick 2003).

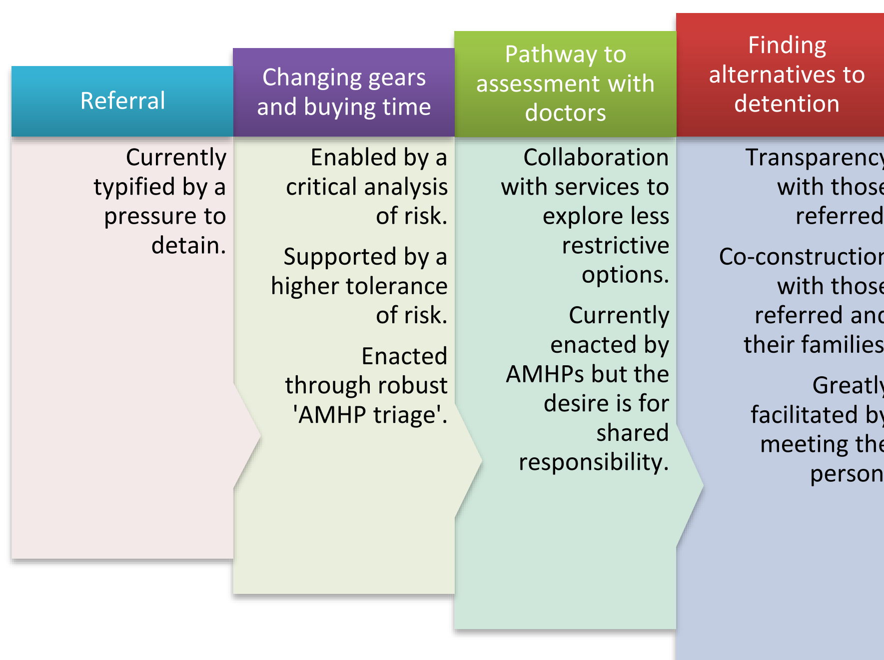

Figure 34: Key learning for practice

Creating pathways to assessment with doctors promotes a sharing of responsibility for finding viable alternatives to detention, providing an opportunity to counter the current trend of risk aversion within mental health services (DHSC 2018). Services that value the role of the AMHP at the point of referral for an MHA assessment will promote systems and a culture that will enable AMHPs to seek to slow the trajectory toward detention and create the necessary time to explore alternative options collaboratively. This is likely to be greatly facilitated by AMHP services safeguarding triage AMHP functions, and leading on developing the appropriate multi-agency forums to explore less restrictive options.

8.8 Further research

Congruent with the appreciative focus of this thesis, I have chosen to emphasise the benefits of further research rather than draw attention to the limitations of this study.

This has been the first study into AMHP decision-making at the point of referral for an MHA assessment. The perspective of nine AMHPs in one Local Authority area when they are

practising at their best has been established, and those AMHPs made some tangible amendments to their service and the way they practised to promote achieving their best more of the time. The data from this study is rich and focussed upon a unique area of practice in one location. Further research in other geographical areas would help ascertain the degree to which AMHPs collectively share the same perception of best practice. There may be geographical variations as identified in ASW detention decisions (Quirk et al. 2003).

Some may be motivated to explore this experience from a different methodological perspective, where the best of practice is not the focus. Doing so could highlight different findings of relevance to practice, and would provide an interesting comparison to this study.

This study has focussed solely on the views of AMHPs about the best of their decision-making at the point of referral for an MHA assessment. Future studies may consider other stakeholder views, and in particular I would be interested in the views of those who have been the subject of these considerations, whether or not those considerations led ultimately to detention in hospital. Blakley et al. (2022) have identified some findings that resonate with the AMHP views in this study and so exploring this further could have additional tangible benefits for practice. Doing so appreciatively is likely to generate more positive practice developments.

Clear benefits for AMHPs have been identified in this study when facilitated to define the best of their practice in a socially constructed sense, and then pragmatically create service structures then enable them to achieve this more of the time. What this study has not established is whether such measures impact upon the overall outcome for those referred. A quantitative study looking at detention rates before and after such service adaptations might provide such insights.

Combining the findings from this study with further research into the point of referral for an MHA assessment may present opportunities to inform national practice guidance, in particular in light of the current MHA review that will lead to an associated review of the MHA Code of Practice (DoH 2015). As the first narrative on this topic this study represents a key source of evidence for such a review, and I understand from a submission to the Joint Committee on the Draft Mental Health Bill from the AMHP Leads Network, that there is wider interest in s 13(1), with a recommendation for guidance to be included in the next version of the Code of Practice, possibly some amendments to s 13 itself (Joint Committee

on the Draft Mental Health Bill 2022). Recognition in the next version of the MHA Code of Practice that AMHPs make a significant decision at the point of referral would be a positive step. Deconstructing notions of what constitutes an MHA assessment, and recognising a pathway that collaboratively seeks to promote less restriction would be another.

8.9 Regional and national scale-up of findings

This study into AMHP decision-making at the point of referral for an MHA assessment offers the first narrative based on empirical research that challenges current normative AMHP practice. When exploring the best of their practice AMHPs in this study identified practice at the point of referral for an MHA assessment that is inclusive and holistic, more aligned with a process of assessment and investigation than a process of screening or rapid progression to an assessment with doctors. In deconstructing examples of best practice, AMHPs identified that the imperative to assess based on pressure relating to risk concerns can often be undermined, slowing down the process to enable a more considered approach. AMHPs in this study reshaped their practice reality in social constructionist terms, creating a new reality founded on the best of their practice and rooted in hopefulness as conceptualised pragmatically.

Many AMHP services are not structured to support practising in this way, and so while there is nothing in law or practice guidance that prevents individual AMHPs from adopting this approach, without support from the service doing so may be challenging for individuals. Services that support quickly assessing with doctors will view the practice described in this AI as deviance from reality in social constructionist terms (Berger and Luckman 1966). Yet it is clear there is wider interest in reconceptualising the point of referral and establishing pathways to assessment, with the aforementioned stance from the AMHP Leads Network and some regional interest in the service developments from this AI.

The insights offered from this AI supported the AMHPs involved to better understand what they wanted to achieve at the point of referral for an MHA assessment. The service developments from this AI aided a cultural shift within the service and across partner agencies, reshaping practice beyond those involved in the research. Appreciative Inquiries are ever evolving processes, and in this case the service design elements have enabled AMHPs to reshape their practice beyond the service design elements to the level of practice culture. This study now offers a platform for broader influence: Shining a light on

this new approach to practice locally has influenced local practice; regionally through networks and inclusion in a local AMHP programme further interest is being gained; it is my intention to publish my findings, broadening my readership to a national level. This will be enhanced by my presentation at a forthcoming national AMHP conference, and my inclusion in redrafting the Code of Practice guidance on this area of practice when the time comes (personal communication, 24th November 2022, available on request).

The strength of the findings from this AI are in their simplicity and coherence for practice. The version of AMHP practice promoted here is consistent with the principles in the Code of Practice (DoH 2015, chapter 1.1), aligned with a desire to reduce compulsion and develop a more rights based mental health system (DHSC 2018), and achievable in practice based on our legacy meetings. Yet within this simplicity and coherence lies a radical shift for many AMHPs and AMHP services, requiring a reconceptualisation of socially constructed realities of practice that support swift transition to assessments with doctors. With legislative reform on the horizon, and a growing AMHP research community in the last 10-years or so, now is the time to promote narratives that challenge traditionally accepted practices.

Chapter 9 Conclusion

9.1 The beginning

I began this research journey as an AMHP with a desire to explore an area of practice neglected in research and guidance, specifically the complex decision AMHPs are required to make at the point of referral for an MHA assessment, where the legislation requires them to "consider the patient's case" (MHA 1983, s 13(1)). I wanted to know more about how AMHPs approached this decision and was keen to derive some practical benefit from this research endeavour.

During the course of this research I have moved from AMHP Lead to AMHP Manager, then part-time academic and part-time AMHP, retaining my involvement with the same AMHP team throughout. While my identity as an AMHP has been retained during this journey, the process of this study has caused me to reshape my practice. Decision-making surrounding detention under the MHA 1983 creates many tensions for AMHPs (Campbell 2010), myself included. On reflection there were aspects of my practice that I felt particularly uncomfortable with, perhaps aligned with the observation that AMHPs have lost their social perspective (Fish 2022). Grace (2015) suggested that the MHA assessment is experienced as procedural; Abbott (2018) found that the voice of the person is absent from assessments; Blakley et al. (2022) highlighted a sense of disempowerment from the MHA assessment process. These observations have all validated my rationale for undertaking this study which has proven not just a quest for knowledge, but a personal and professional transformational experience.

9.2 Methodology

My interest in the point of referral for an MHA assessment was born out of my practice as an AMHP. This "practice puzzle" (Lunt et al. 2012, p.187) germinated over ten years, culminating in my decision to carry out this research. I was naive to research when I started this study, and I found it difficult to identify a research methodology that felt suitable. I was repeatedly struck by the negative bias toward practice, that I felt would alienate my participants who would also be my colleagues. As a practitioner I was not seeking to problematise practice, rather I wanted to recognise the complexity of practice and explore how AMHPs respond to this complexity. I did not wish to be critical of practice and I did not consider the opinions of researchers to be ascendent to those of practitioners. As a practitioner I was keen to harness practice knowledge.

Finding AI as a methodology was pivotal; I immediately connected with its positive focus and collaborative nature, which felt like the perfect corrective to a culture of fear, as identified by Allen and McCusker (2020) as prominent in the equivalent role in Scotland.

Much of the AI literature related to organisational development, but it was first developed by David Cooperrider as a health research methodology (Cooperrider and Srivastva 1987). I read an article by Liebling et al. (1999) about prisoner and prison officer relationships, and immediately saw the parallel with AMHP practice. AMHPs practise within a context that brings them criticism based on the nature of decisions that are destined to always be unacceptable to someone (Campbell 2010). The result is that in my experience AMHPs can be cautious about discussing their practice for fear of criticism, a position equally identified by Stanford (2010) in relation to social work practice. The rationale for utilising AI for Liebling et al. (1999) was to counterbalance the negative perspective about prison officers and therefore promote greater engagement in the research process. I could see the same applying to AMHPs, with a methodology founded upon strengths more likely to bring the best out of participants and lead to tangible positive outcomes. My motivation with this research was to generate new insights into practice with participants, that could be used by practitioners meaningfully.

There is a natural affiliation between AI and social work values of empowerment and strengths-based practice (SWE 2019), and my belief in the methodology has only strengthened through my experience of it. Pooler et al. (2014b) experienced the transformative nature of a positive narrative, very much reflected in this AI. In a climate of risk aversion (DHSC 2018), and a culture where accountability permeates detention decisions (Peay 2003; Skinner 2006), a methodology that began with identifying the positive core of practice, and then built on this, had a liberating effect on participants that inspired our belief in achieving aspirational practice goals. This aligns with the positive and anticipatory principles of AI, where a focus on positives is fateful and moves practice in a positive direction (Whitney and Trosten-Bloom 2010).

Developing a clear understanding of the positive core of AMHP practice at the point of referral for an MHA assessment, was redemptive: as a participant myself, I was able to reconnect with the AMHP I was trying to be, without previously recognising what that was. This was hugely validating, something echoed by the other participants. Even the focus of the AI was validating and fateful, highlighting an area of practice little discussed but frequently experienced as complex. Each of us experienced the simultaneity principle in

action, where the focus on an area of practice begins to change that practice (Whitney and Trosten-Bloom 2010). With a greater clarity and shared understanding of our purpose, we were able to shape our future ideal and align our practice with these goals. With clearer goals our confidence increased as reflected in the legacy meetings.

My role within this AI was as a participant and a researcher, aligned with the role of the other contributors. I facilitated the workshops by introducing each activity, but everyone then contributed to the creation and analysis of the data, moving through the research process to generate outcomes of value for those taking part. Porter (2007) identified the applicability to practice as a defining feature of rigour, and so while my influence on the research was overtly accepted, the outcomes support the validity of the findings. Later thematic analysis after the workshops was interpretive, but this was a regressive approach, working backwards from the final themes to provide a greater degree of clarity about the way in which the participant researchers generated those themes, based on the notes they made during the workshops. The discussion chapter included further interpretation of the findings, situating this AI in the context of other related research and academic opinion.

9.3 Criticality

AI may be criticised for its positive bias (Reed 2007), but as a practitioner seeking some practice-based benefits from this study I saw no problem with this. From a research criticality perspective, Fitzgerald et al. (2010) offered the perfect conceptualisation of the shadow metaphor: by highlighting the best of practice, the inevitable result is that there will be practice outside of the best. Identifying the best encourages higher expectations of practice, promoting growth and development. My intention to shine a light on practice became amended through the use of AI: the best of practice would be highlighted, providing some recognition that this isn’t always achieved, but focussing attention on what use we could make of our knowledge about our practice when it is at its best.

9.4 Literature review

Any mention of the point of referral for an MHA assessment in the literature was fleeting, with decision-making considered to be outside of any legal framework. In my literature review into ASW/AMHP detention decisions risk was dominant, but the morality theme emerged from my interpretive analysis of a broad range of literature spanning more than thirty years. I became inspired to ascertain whether this theme was relevant to decisions at the point of referral for an MHA assessment.

9.5 Methods

I utilised a workshop format for this AI, and as both a researcher and participant I found the positive discussions about practice liberating, something equally reflected by other researcher participants. The chance to reflect on our best experiences, and consider why those experiences were our best, generated a lot of energy toward enhancing these benefits for practice more generally. The unspoken shadow (Fitzgerald et al. 2010) was that we weren't achieving this all of the time, but rather than dwell on the times our practice did not reach our ideals, the freedom to focus on clarifying what we wanted to achieve and to make this happen more, was what became the transformative aspect of this research process. In social constructionist terms, we created a reality of practice that our legacy meetings highlighted was a shift in a positive direction, and pragmatically whatever the reality of practice was before the study, philosophical hopefulness (Koopman 2006) enabled us to derive benefits for practice from this research.

9.6 Philosophy

This qualitative study has been founded upon an interpretive philosophical position accepting a world of multiple realities, principally through the lens of social constructionism, where reality is created between people through verbalising ideas (Berger and Luckman 1966). There was a strong resonance of this through the workshops, where our thoughts about practice seemed to take form through the discussions. There was a sense of validation experienced from putting into words thoughts and feelings formerly unspoken or unacknowledged, and learning that others had similar thoughts and feelings. This collaborative meaning-making extended into the realities created between AMHPs and those referred for an assessment, where a strong emphasis was placed on how AMHPs try to work with those referred to understand their experience. Transparency about risk, and notions of shared decision-making in the context of these constructed realities, were prevalent throughout the workshops. In the same way AI fit so well with social work practice, social constructionism seemed to share that affinity with the values and aspirations of emancipation and collaboration (SWE 2019). Such a philosophical position sits in stark contrast to prominent medicalised approaches to the diagnosis and treatment of mental disorder (Rogers and Pilgrim 2014), with a more positivist conceptualisation of the reality of when hospital may be required leading to more paternalistic responses. Abendstern et al. (2021) found social workers in mental health settings were advocates, providing a bridge between the service user and the service, or perhaps viewed

philosophically a bridge between two reality constructs. This has been validated in this AI through the emphasis on collaboration.

Social constructionism was equally prevalent in notions raised throughout the workshops about the benefits of peer and team support to help clarify opinions, draw on the experience of others, and validate decisions. These conversations served to create a working reality to base decisions upon. This was extended to other teams through pathways to assessment with doctors, and sharing in the exploration of alternative options, thus drawing a network of professionals into a shared sense of reality.

Together with social constructionism, there is an influence of pragmatism in AI given the goal was practice development. The focus for pragmatism is not in defining reality, but in what we can do with the knowledge we create (Deforge and Shaw 2012). Koopman (2006) merged this with hopefulness which provides a further parallel to AI, where the focus is the appreciation of the best of practice. In this AI, I don't see social constructionism and pragmatism as mutually exclusive, rather the definition of the reality of practice can be understood through social constructionism, but how we apply that can equally be understood through the lens of pragmatism.

9.7 Findings

Our findings created new knowledge about the practice that AMHPs strive to achieve, based on what AMHPs currently achieve when they are at their best. There was universal agreement that a referral for an MHA assessment was a significant point requiring an active decision. There was also universal agreement about the importance of time, specifically the desire to create more time for thorough exploration of less restrictive alternatives. Crucially, AMHPs considered their ability to analyse risk represented a unique skill, and that peer support contributed to maintaining a higher risk threshold than other professionals. My literature review had identified risk as a significant theme in ASW/AMHP detention decisions, and this AI validated how pivotal risk is. AMHPs started from a position that risks were likely to be inflated by other professionals, and as such they focussed early attention on risk analysis, to identify weaknesses in the rationale for a quick response. Regehr et al. (2022) found that a focus on threat stimuli led to poor decisions, and this AI has demonstrated how AMHPs sought to redress this, by creating time through undermining risk rationale, combined with higher risk tolerance.

Creating more time enabled AMHPs in this study to work collaboratively with the person, often meeting them in person, and connecting with work that is essentially social (Pooley et al. 2014a).

Pragmatically, AMHPs felt that decision-making at the point of referral for an MHA assessment, required elevated importance within the service, leading to the creation of the *triage AMHP* role. A pathway to assessment with doctors was conceptualised, that would include support from a range of agencies much like the blue light protocol for learning disabilities (NHS England 2015). On a case-by-case basis these meetings did start to happen in the service.

Through connecting with the person referred, AMHPs in this study demonstrated their motivation to achieve less restrictive practice, valuing the wishes and feelings of the person, and promoting their right to liberty (HRA 1998, article 5). Proceeding to an assessment with doctors, and ultimately detention, became more acceptable in situations that appropriate efforts to avoid this outcome had been made by the AMHP themselves, highlighting the importance of a connection with the person prior to making a decision to detain. This was equally supported from my literature review into ASW/AMHP detention decisions.

9.8 Implications for AMHP services

This AI has highlighted that AMHPs in this study considered an assessment was required at the point of referral for an MHA assessment, before any decision to involve doctors was made. This assessment would take time, and an analysis of risk based on a belief those risks were overinflated, was the mechanism by which more time was created. The decision at the point of referral became the detention decision, and a collaborative and holistic assessment was the goal. Multi-agency collaboration, through meetings to seek alternatives to detention, were advocated. The desire for a personal connection with the person referred was dominant, supporting the moral nature of the decision. The necessity for the service to acknowledge the time required for AMHPs to complete the assessment at the point of referral, led to the creation of the *triage AMHP* role and the *s 13.1 AMHP report*, also validating the statutory nature of the decision and enhancing consistency within the service.

9.9 Final comments

Receiving a referral for an MHA assessment, and making a decision about the most appropriate response, is a complex area of AMHP practice. The likelihood of detention following assessment with doctors sharpens the significance of the decision at the point of referral, and the process of this AI has facilitated reflections upon the best of practice, leading to service design changes to maximise the identified practice goals. The result, for those involved in the study, has been greater clarity about what we are trying to achieve when we receive a referral, greater confidence in dealing with referrals, our practice has become less reactive and more considered and collaborative, and our decisions to detain have become more acceptable given our greater efforts to avoid detention. Our service is now structured to reflect our practice ideals, and we feel a greater sense of pride from our enhanced ability to perform the AMHP role in a way that aligns with our personal and professional values.

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Mental Health Act 1959.

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Mental Health (Approved Mental Health Professional) (Approval) (England) Regulations 2008, SI 2008/1206.

Mental Health (Care and Treatment) (Scotland) Act 2003

Mental Health (Northern Ireland) Order 1986

Mental Treatment Act 1930.

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11.

P v Cheshire West & Chester Council; P & Q v Surrey County Council [2014] UKSC 19

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United Nations Human Rights Council (UNHRC). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (28 March 2017) UN Doc A/HRC/35/21.

Appendix 1 Example critical synopsis

Marriott, S., Audini, B., Lelliott, P., Webb, Y., Duffett, R. (2001) Research into the Mental Health Act: A qualitative study of the views of those using or affected by it. Journal of Mental Health, 10, 1, 33-39.

a) Why am I reading this?

This article came up in my literature search and the title suggests it is about the views of people using the Act, which would include AMHPs. It is a qualitative study. It is not clear whether decision-making will feature.

b) What are the authors trying to do in writing this?

This is a department of health funded study reviewing the problems encountered in routine practice, the application of the Act as it stands, and the relevance to current service organisation and resources.

c) What are the authors saying that is relevant to what I want to find out?

The authors identified uncertainty in interpreting the criteria for detention as a theme. They suggest participants were unclear what the terms nature or degree of mental disorder mean; there was little evidence of a systematic approach to interpreting "for the protection of others"; and "to prevent a deterioration in the patients health" [interesting as this is not part of the Act]. Participants considered the assessment of a patient's informed consent and mental capacity to be difficult due to the fluctuating nature of mental capacity and also they found distinguishing between partial and complete capacity difficult [Interesting as this is not part of the Act].

d) How convincing is what the authors are saying?

There are limitations to this study regarding its applicability to this literature search. Firstly, of 82 participants only 10 were AMHPs, and the conclusions drawn from the participants do not stipulate which participants the conclusions relate to. A particular limitation is that knowledge of the Act was identified as poor across all groups apart from ASWs, then the conclusions which do relate to decision-making were largely relating to interpreting the Act. Consequently it is possible the only conclusions relating to decision-making do not in fact relate to AMHP decision-making.

e) In conclusion, what use can I make of this?

Given the impossibility of isolating ASW views from those of other participants and the high likelihood that the decision-making conclusions were not drawn from the ASW participants I can only conclude this study does not relate to ASW decision-making.

Appendix 2 Literature review search results.

An EBSCOhost database search was conducted using Boolean operators. The following terms were used: “Approved mental health pr*” OR “approved social work*” AND TI/AB “decision making” OR decision-making OR deciding OR decision# OR uncertainty OR risk OR experience# OR complexit*. The terms uncertainty, risk, experience and complexity were included due to their prevalence in the literature during the initial exploration phase. Only peer reviewed academic papers were included to enhance the possibility that the sources would be trustworthy having received validation by experts in the field. This rationale was extended to include doctoral theses.

Results: 81 (78 once duplicates and this literature review removed).

1. Simpson, M., 2020. A Structured Narrative Literature Review of Approved Mental Health Professional Detention Decisions: An Infusion of Morality, *Practice*, 32(4), 285–300.
    a. This is my literature review so it is not included.

2. Abbott, S., 2022. Study Exploring How Social Work AMHPs Experience Assessment under Mental Health Law: Implications for Human Rights-Oriented Social Work Practice, *British Journal of Social Work*, 52(3), 1362–1379.
    a. A less detailed published article from an included doctoral thesis (Abbott 2018).
    b. Excluded from title/abstract based on knowledge of the full study included.

3. Buckland, R., 2016. The Decision by Approved Mental Health Professionals to Use Compulsory Powers under the Mental Health Act 1983: A Foucauldian Discourse Analysis, *British Journal of Social Work*, 46(1), 46–62.
    a. Included.

4. Stone, K., 2019. Approved Mental Health Professionals and Detention: An Exploration of Professional Differences and Similarities, *Practice*, 31(2), 83–96.
    a. A less detailed published article from an included doctoral thesis (Stone 2017).
    b. Excluded from title/abstract based on knowledge of the full study included.

5. Fish, J. L. H., 2022. The lost social perspective: relocating the social perspective in approved mental health practice and the Mental Health Act 1983, *Journal of Social Welfare & Family Law*, 44,(1), 3–21.

    a. There is limited mention of specific factors in AMHP detention decisions. I don't think this article adds anything to the literature review.

    b. Excluded through synopsis.

6. O'Hare, P., Davidson, G., Campbell, J. and Maas-Lowit, M., 2013. Implementing mental health law: a comparison of social work practice across three jurisdictions, *Journal of Mental Health Training, Education & Practice*, 8,(4), 196–207.

    a. Included.

7. Dixon, J., Wilkinson, T. M., Stone, K. and Laing, J., 2020. Treading a tightrope: Professional perspectives on balancing the rights of patient's and relative's under the Mental Health Act in England, *Health & Social Care in the Community*, 28(1), 300–308.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

8. Hall, P., 2017. Mental Health Act Assessments – Professional Narratives on Alternatives to Hospital Admission, *Journal of Social Work Practice*, 31(4), 445–459.

    a. Included.

9. Karban, K., Sparkes, T., Benson, S., Kilyon, J. and Lawrence, J., 2021. Accounting for Social Perspectives: An Exploratory Study of Approved Mental Health Professional Practice, *British Journal of Social Work*, 51(1), 187–204.

    a. Included in addition to original published literature review.

10. Stevens, M., Manthorpe, J., Martineau, S., Steils, N. and Norrie, C., 2021. An exploration of why health professionals seek to hold statutory powers in mental health services in England: considerations of the approved mental health professional role, *Journal of Mental Health*, 30(5), 571–577.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

11. Stone, K., Vicary, S., Scott, C. and Buckland, R., 2020. 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, *Ethics & Social Welfare*, 14(2), 156–171.

    a. Not about AMHP detention decisions.

    b. Excluded from title/abstract.

12. Stone, K. M. C., 2017. Decisions on risk and mental health hospital admission by approved mental health professionals. Unpublished doctoral thesis.

    a. Included.

13. Stone, K., 2019. Nurse AMHPs: an exploratory study of their experiences, *Journal of Mental Health Training, Education & Practice*, 14(2), 86–95.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

14. 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?, *British Journal of Social Work*, 39(5), 901–917.

    a. Not about detention decisions.

    b. Excluded through synopsis.

15. Bonnet, M. and Moran, N., 2020. Why Do Approved Mental Health Professionals Think Detentions under the Mental Health Act Are Rising and What Do They Think Should Be Done about It?, *British Journal of Social Work*, 50(2), 616–633.

    a. Included in addition to original published literature review.

16. Campbell, J. and Davidson, G., 2017. Understanding risk and coercion in the use of community-based mental health laws, *in* Stanford, S., Sharland, E., Heller, N. R. and Warner, J (eds), *Beyond the risk paradigm in mental health policy and practice*, New York: Palgrave Macmillan, 17–29.

    a. Books are not being included unless referenced by other sources to demonstrate validity.

    b. Excluded from title/abstract.

17. Davidson, G. and Campbell, J., 2010. An audit of assessment and reporting by Approved Social Workers (ASWs), *British Journal of Social Work*, 40(5), 1609–1627.

    a. This study does not address AMHP decision-making under the English Mental Health Act.

    b. Excluded through synopsis.

18. Gregor, C., 2010. Unconscious Aspects of Statutory Mental Health Social Work: Emotional Labour and the Approved Mental Health Professional, *Journal of Social Work Practice*, 24(4), 429–443.

    a. Included.

19. Fish, J. L. H., 2022. Genericism and managerialism: The limits to AMHP professionalisation and expertise, *International Journal of Law & Psychiatry*, 83, https://doi.org/10.1016/j.ijlp.2022.101818.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

20. Vicary, S., 2021. “Pull;” the Active Use of Dissonance. An IPA Pearl to Show Emotion Management in Action, *Practice*, 33(4), 253–270.

    a. A less detailed published article from an included doctoral thesis (Vicary 2017).

    b. Excluded from title/abstract based on knowledge of the complete study included with Vicary 2017.

21. Smith, M. S., 2015. “Only connect” “nearest relative’s” experiences of mental health act assessments, *Journal of Social Work Practice*, 29(3), 339–353.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

22. Laing, J., Dixon, J., Stone, K. and Wilkinson-Tough, M., 2018. The nearest relative in the Mental Health Act 2007: still an illusionary and inconsistent safeguard?, *Journal of Social Welfare & Family Law*, 40(1), 37–56.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

23. Walton, P., 2000. Reforming the Mental Health Act 1983: an approved social worker perspective, *Journal of Social Welfare & Family Law*, 22(4), 401–414.
    a. While highly relevant to legislative change the submissions in this article do not contribute to understanding ASW decision-making.
    b. Excluded through synopsis.

24. Buckland, R., 2020. Power as Perceived in MHA Assessment Contexts: A Scoping Review of the Literature, *Practice*, 32(4), 253–267.
    a. Little of relevance. That which is relevant is cited from other sources and as such does not add anything to this literature review.
    b. Excluded through synopsis.

25. Bailey, D. and Liyanage, L., 2012 The Role of the Mental Health Social Worker: Political Pawns in the Reconfiguration of Adult Health and Social Care, *British Journal of Social Work*, 42(6), 1113–1131.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

26. Banks, L. C., Stroud, J. and Doughty, K., 2016. Community treatment orders: exploring the paradox of personalisation under compulsion, *Health & Social Care in the Community*, 24(6), 181–190.

   a. Not about detention decisions.
   b. Excluded from title/abstract.

27. Morriss, L., 2016. AMHP Work: Dirty or Prestigious? Dirty Work Designations and the Approved Mental Health Professional, *British Journal of Social Work*, 46(3), 703–718.
    a. Included.

28. Hewitt, D., 2015. Not reasonably practicable: are there now greater opportunities for abuse by a nearest relative?, *Journal of Adult Protection*, 17(1), 62–70.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

29. Colombo, A., Bendelow, G., Fulford, B. and Williams, S., 2003. Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams, *Social Science & Medicine*, 56(7), 1557.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

30. Dwyer, S., 2012. Walking the tightrope of a mental health act assessment, *Journal of Social Work Practice*, 26(3), 341–353.
    a. Included

31. Wilson, G., Hamilton, B., Britton, F., Campbell, J., Hughes, P. and Manktelow, R., 2005. Approved Social Work Training in Northern Ireland: Using Research to Examine Competence-based Learning and Influence Policy Change, *Social Work Education*, 24(7), 721–736.
    a. Research outside England and Wales so not about the AMHP role.
    b. Excluded from title/abstract.

32. Morriss, L., 2017. Being Seconded to a Mental Health Trust: The (In)Visibility of Mental Health Social Work, *British Journal of Social Work*, 47(5), 1344–1360.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

33. Webber, M. and Huxley, P., 2004. Social exclusion and risk of emergency compulsory admission. A case-control study, *Social Psychiatry & Psychiatric Epidemiology*, 39(12), 1000–1009.

    a. This is a largely quantitative study and decision-making is not explored.

    b. Excluded through synopsis.

34. Manktelow, R., Hughes, P., Britton, F., Campbell, J., Hamilton, B. and Wilson, G., 2002. The Experience and Practice of Approved Social Workers in Northern Ireland, *British Journal of Social Work*, 32(4), 443.

    a. This study took place in Northern Ireland and therefore was not under the jurisdiction of the Mental Health Act of England and Wales. As such it is not directly applicable because the role and process of assessment is different. In addition, the element of the study that relates to ASW practice is quantitative and therefore lacks detail. Finally the discussion about decision-making is limited and so is not likely to contribute much to the overall literature.

    b. Excluded through synopsis.

35. Smith, M., 2008. The Divine or the Physician? Fears of Ghosts and the Supernatural in Approved Social Work, *Journal of Social Work Practice*, 22(3), 289–299.

    a. Not about detention decisions.

    b. Excluded through synopsis.

36. Campbell, J., Wilson, G., Britton, F., Hamilton, B., Hughes, P. and Manktelow, R., 2001. The management and supervision of Approved Social Workers: Aspects of law, policy and practice, *Journal of Social Welfare & Family Law*, 23(2), 155–172.

    a. This study took place in Northern Ireland and therefore is outside the scope of this review. The ASW role is different due to the different legislation and decision-making is not discussed.

b. Excluded through synopsis.

37. Coyle, D., Macpherson, R., Foy, C., Molodynski, A., Biju, M. and Hayes, J., 2013. Compulsion in the community: Mental health professionals' views and experiences of CTOs, *The Psychiatrist*, 37(10), 315–321.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

38. Hatfield, B., Huxley, P. and Mohamad, H., 1997. Social factors and compulsory detention of psychiatric patients in the U.K. The role of the approved social worker in the 1983 Mental Health Act, *International journal of law and psychiatry*, 20(3), 389–397.

    a. This is another largely quantitative study and decision-making is not explored.

    b. Excluded through synopsis.

39. Stone, K., Vicary, S. and Spencer-Lane, T., 2020. *The Approved Mental Health Professional practice handbook*, Bristol: Policy Press.

    a. Books are not being included unless they have been referenced elsewhere to demonstrate reliability.

    b. Excluded from title/abstract.

40. Peddar, J. and Brazier, C., 2011. Improving outcomes for "failing" students through the use of presentations, *Journal of Practice Teaching & Learning*, 11(1), 80–88.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

41. Marriott, S., Audini, B., Lelliott, P., Webb, Y. and Duffett, R., 2001. Research into the Mental Health Act: a qualitative study of the views of those using or affected by it, *Journal of Mental Health*, 10(1), 33–39.

    a. Given the impossibility of isolating ASW views from those of other participants and the high likelihood that the decision-making conclusions

were not drawn from the ASW participants I can only conclude this study does not relate to ASW decision-making.

b. Excluded through synopsis.

42. Vennum, A. and Vennum, D., 2013. Expanding Our Reach: Marriage and Family Therapists in the Public School System, *Contemporary Family Therapy: An International Journal*, 35(1), 41–58.

    a. Not about AMHP detention decisions.

    b. Excluded from title/abstract.

43. Taylor, C., 1999. Experiences of a pilot project for the Post Qualifying Award in Social Work, *Social Work Education*, 18(1), 71.

    a. Not about ASW/AMHP detention decisions.

    b. Excluded from title/abstract.

44. Yianni, C., 2009. Aces High: My Control Trumps Your Care, *Ethics & Social Welfare*, 3(3), 337–343.

    a. Included.

45. Coffey, M. and Hannigan, B., 2013. New roles for nurses as approved mental health professionals in England and Wales, *International Journal of Nursing Studies*, 50(10), 1423–1430.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

46. Evans, S., Huxley, P., Webber, M., Katona, C., Gately, C., Mears, A., Medina, J., Pajak, S. and Kendall, T., 2005. The impact of "statutory duties" on mental health social workers in the UK, *Health & Social Care in the Community*, 13(2), 145–154.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

47. Nathan, R., Gabbay, M., Boyle, S., Elliott, P., Giebel, C., O'Loughlin, C., Wilson, P. and Saini, P., 2021. Use of Acute Psychiatric Hospitalisation: A Study of the Factors Influencing Decisions to Arrange Acute Admission to Inpatient Mental Health Facilities, *Frontiers in psychiatry*, 12, 891.

    a. Limited relevance. Results that are clearly linked to AMHP contributions don't add anything to the review.

    b. Excluded through synopsis.

48. Hatfield, B., 2008. Powers to detain under mental health legislation in England and the role of the approved social worker: an analysis of patterns and trends under the 1983 Mental Health Act in six local authorities, *British Journal of Social Work*, 38(8), 1553–1571.

    a. This study does not involve decision-making.

    b. Excluded through synopsis.

49. Campbell, J., 2010. Deciding to Detain: The Use of Compulsory Mental Health Law by UK Social Workers, *British Journal of Social Work*, 40(1), 328–334.

    a. Included.

50. Barcham, C., 2008. Understanding The Mental Health Act Changes -- Challenges And Opportunities For Doctors, *British Journal of Medical Practitioners*, 1(2), 13–17.

    a. Not about AMHP detention decisions.

    b. Excluded from title/abstract.

51. Martin, D., 2019. Community Treatment Orders : what do they tell us about the exercise of power over the psychiatric patient? Unpublished doctoral thesis.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

52. Duplication of result 46.

53. Foster, A. and Roberts, V. Z., 1999 Part III: Learning from the experience of face-to-face work: Chapter 11: Integration or fragmentation, *in* Managing Mental Health in the Community, Taylor & Francis Ltd, 133–144.

    a. Books are not being included unless referenced elsewhere to demonstrate validity.

    b. Excluded from title/abstract.

54. Johns, R., 2004. Of Unsound Mind? Mental Health Social Work and the European Convention on Human Rights, *Practice*, 16(4), 247–259.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

55. Duplicate of 19.

56. Hurley, J. and Linsley, P., 2006. Proposed changes to the Mental Health Act of England and Wales: research indicating future educational and training needs for mental health nurses, *Journal of Psychiatric & Mental Health Nursing (Wiley-Blackwell)*, 13(1), 48–54.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

57. Vicary, S, 2017. An Interpretative Phenomenological Analysis of the impact of professional background on role fulfilment : a study of approved mental health practice.

    a. Included.

58. Parkinson, C. and Thompson, P., 1998. Uncertainties, mysteries, doubts and Approved Social Worker Training, *Journal of Social Work Practice*, 12(1), 57–64.

    a. This is an interesting article but there is no direct reference to ASW experiences, rather such references are generalised and theorised.

    b. Excluded through synopsis.

59. Abbott, S. N., 2018. Using the law in social work Approved Mental Health Professional practice.
    a. Included.

60. Beckett, C., 2009. The Ethics of Control, *Ethics & Social Welfare*, 3(3), 229–233.
    a. More general discussion rather than specific to ASW.
    b. Excluded from full text review.

61. Rooke, R., 2020. Facilitating the “least restrictive option and maximising independence” under section 115 Mental Health Act 1983, *Practice*, 32(4), 269–283.
    a. Included in addition to original published literature review.

62. Rapaport, J., 2006. New roles in mental health: the creation of the approved mental health practitioner, *Journal of Integrated Care*, 14(5), 37–46.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

63. Latham, R., Zinkler, M. and Priebe, S. 2021. Hospitalization and civil commitment in England and Wales’, *in* Felthous, A. R., and Saß, H., (eds), *The Wiley international handbook on psychopathic disorders and the law: Laws and policies., Vol. 2, 2nd ed.*, Wiley Blackwell, 25–37.
    a. Books are not being included unless referenced from other sources to demonstrate validity.
    b. Excluded from title/abstract.

64. Huxley, P. and Kerfoot, M., 1994. A Survey of Approved Social Work in England and Wales, *British Journal of Social Work*, 24(3), 311–324.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

65. Richards, P., 2010. Psychosocial practice in inpatient mental health services, *in* Webber, M. and Nathan, J. (eds) *Reflective practice in mental health: Advanced psychosocial practice with children, adolescents and adults.* London: Jessica Kingsley Publishers (Reflective practice in social care series), 234–243.
    a. Books are not being included unless referenced from other sources to demonstrate validity.
    b. Excluded from title/abstract.

66. Evans, S., Huxley, P., Gately, C., Webber, M., Mears, A., Pajak, S., Medina, J., Kendall, T. and Katona, C., 2006. Mental health, burnout and job satisfaction among mental health social workers in England and Wales, *The British Journal of Psychiatry*, 188(1), 75–80.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

67. Jones, S., Williams, B. and Bayliss, M., 2006. Whose job is it anyway?, *Mental Health Nursing*, 26(4), 10–12.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

68. Brimblecombe, N., 2009. New Ways of Working for nurses, *Journal of Mental Health Training, Education & Practice*, 4(3), 4–9.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

69. Galpin, D., and Parker, J., 2007. Adult protection in mental health and inpatient settings: an analysis of the recognition of adult abuse and use of adult protection procedures in working with vulnerable adults, *Journal of Adult Protection*, 9(2), 6–14.
    a. Not about detention decisions.
    b. Excluded from title/abstract.

70. Veitch, P. and Oates, J., 2017. Strange bedfellows? Nurses as responsible clinicians under the Mental Health Act (England & Wales), *Journal of Psychiatric and Mental Health Nursing*, 24(4), 243–251.

    a. Not about AMHPs.

    b. Excluded from title/abstract.

71. Vaughan, P. J., Kelly, M. and Pullen, N., 2001. The working practices of the police in relation to mentally disordered offenders and diversion services, *Medicine, science, and the law*, 41(1), 13–20.

    a. Not about AMHP or detention decisions.

    b. Excluded from title/abstract.

72. Hoyle, C., 2009. Dual diagnosis service development in a male local prison: description of a case study, *Advances in Dual Diagnosis*, 2(1), 5–12.

    a. Not about AMHP or detention decisions.

    b. Excluded from title/abstract.

73. Perry, B. I. and Singh, S. P., 2017. On psychiatry unlocked, *The Lancet Psychiatry*, 4(7), 519–520.

    a. Not about AMHP or detention decisions.

    b. Excluded from title/abstract.

74. Sashidharan, S. P., Bhui, K. and Duffy, J., 2014. "Ethnicity as a predictor of detention under the Mental Health Act": A response to Singh et al, *Psychological Medicine*, 44(4), 893–894.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

75. Harbour, A., 2008. *Children with mental disorder and the law: A guide to law and practice*, London: Jessica Kingsley Publishers.

a. Books are not included unless referenced elsewhere to demonstrate validity.

b. Excluded from title/abstract.

76. Slater, T., 2014. Exploring the role of social workers in suicide prevention. Unpublished doctoral thesis.

    a. Not about AMHP detention decisions.

    b. Excluded from title/abstract.

77. Huxley, P. J. and Kerfoot, M., 1993. Variation in requests to social services departments for assessment for compulsory psychiatric admission, *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, 28(2), 71–76.

    a. Not about detention decisions.

    b. Excluded from title/abstract.

78. Stockwell, S., 2008. Review of The nearest relative handbook, *Practice*, vol. 20(4), 277–278.

    a. Not about AMHP or detention decisions.

79. Hatfield, B., Mohamad, H. and Huxley, P., 1992. The 1983 Mental Health Act in five local authorities: a study of the practice of approved social workers, *The International journal of social psychiatry*, 38(3), 189–207.

    a. Decision-making is not incorporated into the study.

    b. Excluded through synopsis.

80. Fenton, J. W., O'Hanlon, D. and Allen, D., 2003. Does having been on a "section" reduce your chances of getting a job?, *Psychiatric Bulletin*, 27(5), 177–178.

    a. Not about AMHP or decision making.

    b. Excluded from title/abstract.

81. Dunn, L. M., 2001. Mental Health Act assessments: does a community treatment team make a difference?, *The International journal of social psychiatry*, 47(2), 1–19.
    a. This study is largely quantitative and does not relate to my literature review closely enough to be relevant.
    b. Excluded through synopsis.

Total: 11 original articles used in the published paper.

3 additional articles published subsequently.

Texts that arose in the original search in 2019 prior to publication but did not arise in the 2022 search, but that have been used in the literature review:

1. Haynes, R., 1990. After 1983: Approved social workers' perceptions of their changing role in emergency psychiatric assessments, *Practice*, 4(3), 184-198.

2. Thompson, P., 1997. Approved social work and psychotherapy, *Practice*, 9(2), 35-46.

3. Sheppard, M., 1993. Theory for Approved Social Work: the use of the Compulsory Admissions Assessment Schedule, *British Journal of Social Work*, 23, 231-257.

4. Smith, M., 2001. Risk assessment in mental health work, *Practice*, 13(2), 21-30.

Those excluded from the review following synopsis:

1. Webster, J., Hatfield, B. and Mohamad. H., 1999. Assessment of parents by approved social workers under the Mental Health Act 1983, *Practice*, 11(2), 5-18.
    a. The focus is very much on the quantitative data and as such decision-making is not overtly addressed.
    b. Excluded through synopsis.

2. Glover-Thomas, N., 2010. The Mental Health Act 2007 of England and Wales: The impact on perceived patient risk profiles, *Medical Law*, 29, 593-607.

    a. This article was written part way through a study being conducted by the author. There is little direct discussion of the empirical evidence as it has not yet been fully collected and analysed. Once the study was completed the author wrote another article that has formed part of this literature review.

    b. Excluded through synopsis.

3. Roberts, C. Peay, J. and Eastman, N., 2002. Mental Health Professionals' Attitudes Towards Legal Compulsion: Report of a National Survey, *International Journal of Forensic Mental Health*, 1(1), 71-82.

    a. There is little relating to decision-making.

    b. Excluded through synopsis.

4. Bowers, L., Clark, N. and 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, *British Journal of Social Work*, 33, 961-968.

    a. As decision-making is not discussed I cannot make use of this study.

    b. Excluded through synopsis.

5. Thompson, P., 1997. Practice at the outer limits of approved social work, *Practice*, 9(4), 57-65.

    a. This paper offers only minimal analysis and no knew knowledge is introduced.

    b. Excluded through synopsis.

6. Beveridge, A., 1998. Psychology of Compulsion, *Psychiatric Bulletin*, 22, 115-117.

    a. This is about decision-making under the Mental Health Act but it is from the perspective of psychiatrists and it is outside the jurisdiction of the Mental Health Act of England and Wales.

   b. Excluded through synopsis.

7. Sheppard, M., 1991. Referral source and process of assessment: A comparative analysis of assessments for compulsory admission under The Mental Health Act, 1983, *Practice*, 5(4), 284-298.

   a. Decision-making is not discussed. The study is largely quantitative.

   b. Excluded through synopsis.

8. Bhugra, D. and Dazzan, P., 2000. Use of the Mental Health Act Criteria in the Decision-Making Process for Compulsory Admissions: A Study of Psychiatrists in South London, *Medical Science Law*, 40(4), 336-344.

   a. As this study is about psychiatrists it falls outside the scope of my literature search.

   b. Excluded through synopsis.

Ethos search additional results:

Terms: mental health act assessment.

Results: 143

1. Lingard, R., 2007. A qualitative investigation of informal carers' experience of the assessment and detention of their relative/friend under the Mental Health Act (MHA).

   a. Not about AMHP decision making.

   b. Excluded from title/abstract.

2. Skinner, L., 2006. Negotiating uncertainty: mental health professionals' experiences of the Mental Health Act assessment process.

   a. Included.

3. Brammer, A., 2020. A case study of the factors and processes involved in the use of compulsory powers when carrying out Mental Health Act 1983 (Amended 2007) community assessments, from the perspectives of Approved Mental Health

Professionals in one local authority in the North of England : a Critical Realist perspective.

   a. Included in addition to original published literature review.

4. Grace, J. D, 2015. The experience of being assessed and detained under the Mental Health Act (1983) : an interpretative phenomenological analysis.

   a. The focus of the research is on service user views which are not relevant to my literature search question.

   b. Excluded through synopsis.

5. Stone, K. M. C., 2017. Decisions on risk and mental health hospital admission by approved mental health professionals.

   a. Already included.

6. Ball, L. F. J., 2013. Decisions on risk and mental health hospital admission by approved mental health professionals.

   a. Specific to older adults so results can't be generalised.

   b. Excluded following full text review.

7. Abbott, S. N., 2018. Using the law in social work Approved Mental Health Professional practice.

   a. Already included.

8. Dixon, M., 2005. Risk assessment for compulsory detention under the Mental Health Act (1983) : a grounded analysis of psychiatrists' perspectives.

   a. Not about AMHPs.

   b. Excluded from title/abstract.

Appendix 3 Thematic analysis

Theme	Codes
Morality	Inherent contradiction/tension between care and control (Campbell; Buckland; Morriss; Yianni; Skinner). Focus on the person (Vicary; Dwyer) Personhood (Vicary) Less sure about compulsion after watching video (Peay) Desire to gain more information and/or get to know the person (Peay; Rooke) Shift to a right to treatment perspective (Buckland) Values override legislation (Buckland) Greater importance of first detention (Buckland) Detention pragmatic (Quirk; Brammer) Ideological/philosophical orientation (Quirk) Dirty work? (Quirk; Morriss) Process feeling barbaric (Dwyer) Gather information socially constructed (Hall; Peay; Abbott) vs medically constructed (Sheppard; Buckland; O'Hare) Risk of detention (Kinney; Smith; Brammer) Balance of what is less-worse (Quirk) Easier to detain (Kinney) Rights of family members and others given priority over the rights of the patient (Abbott) Soft paternalism vs hard paternalism (Fistein)
Risk	Threshold of risk (Sheppard; Quirk; Brammer) Lack of clarity about risk (Sheppard) Presumption of risk based on mental disorder (Sheppard) Individual tolerance of risk (Stone) Variation in how risk is defined (Glover-Thomas) Risk as a key theme (Peay; Karban; Brammer) Uncertain risk (Peay) Social construct of risk (Stone) Risk as key ASW concern (Sheppard; Kinney; Brammer) Ambiguity about thresholds (O'Hare) Arbitrary understanding of how risk informs judgement (O'Hare) Lower threshold for unknowns – err on the side of caution (Glover-Thomas). Knowing the person enables greater tolerance of risk (Stone) Risk is self-evident (Glover-Thomas) Past behaviour determines current risk (Glover-Thomas) Can't define risk but know it when see it (Glover-Thomas) Preoccupation with impact of risk on others (Abbott) Desire for risk to be contained (Abbott) Mental health orientation (Sheppard) Problematisation of mental disorder (Buckland) Clinical history prejudicial (Glover-Thomas) Frame crisis as social (Hall)
Accountability	Personal accountability – focus of anxiety (Buckland)

	Personal responsibility (Thompson) Defensive practice (O'Hare; Brammer) Liability (Skinner) Stress due to accountability (Gregor) Stress because professional risk not worth it (Kinney) Anxiety due to personal accountability (Gregor) Fear due to accountability (Peay) Autonomy is important to AMHPs (Abbott) Repercussions (Glover-Thomas 2018) Accountability (Fistein)
Emotional	Fatigue leading to a failure to thoroughly investigate (Haynes) Decision is emotional and cognitive (Dwyer) Open mind (Thompson) Mental stillness (Dwyer) Satisfaction and pride (Vicary) Contradictory emotions required to control practice (Vicary) Full speed but careful thought (Dwyer) Support from colleagues (Quirk, Dwyer) Guilt/ weight of the decision (Morriss) Fear of being assaulted (Stone) Fear of the environment (Stone) Anxiety transferred from service user (Thompson) Physical appearance of service user affects how the ASW feels (Thompson) Absorb stress of others (Gregor) Container – Bion / focal point for anxiety (Dwyer; Thompson, Buckland) Deep feelings (Dwyer) Unwilling partnership between service user and ASW (Thompson) Fraught situations not conducive to thought – Bion (Dwyer)
Intuition	Gut instinct (Glover-Thomas) Intuition (Stone; Brammer) Common sense (Gregor; Buckland) Bodily metaphors and human-ness (Buckland) Suspicions, feelings (Kinney) Experience (Stone) Practice wisdom (Vicary; Stone; Dwyer; Brammer) Familiarity with the role makes the role intrinsic (Stone) Assimilate role into identity (Skinner; Vicary; Karban) Embodiment of personhood (Vicary) "Right decision" "best thing" "right reasons" (Morriss; Dwyer) Fear of making the "wrong decision" (Stone) Initial impressions pervasive (Peay) Increased confidence with more information (Peay) Seek supporting evidence, disregard contradictory evidence (Buckland) Weigh usefulness of information and the quality of the judgement of others (Dwyer; Brammer) Trusted sources more likely to be taken at face value (Quirk) Sift through chaos and draw out what is important (Dwyer)

	Develop hypothesis which continue to test (Quirk) Informal assessment and case construction leading to a clear expectation of outcome (Quirk) Variability within and between groups (Peay; Stone) Subjectivity (Stone) Constantly question decision (Hall) Increased awareness of complexity with experience (Gregor) Use of assumption-based reasoning (Skinner) Balance of advantages and disadvantages (Skinner) More weight to the story of close family member than person being assessed (Abbott) Treatability intuitive (Fistein)
Pressure/Coercion	Competing roles (Skinner) Conflict (Haynes) Pressure to reach a decision quickly (Kinney) Internal and external conflict (Skinner; Brammer) Pressure from employer (Thompson) Competing organisational and resource demands (Campbell) Lobbying (Quirk) Organisational pressures (Thompson) Working with trusted doctors supportive (Abbott) Support of the team helpful (Quirk)
Uncertainty	Contradiction and uncertainty (Skinner) Expect the unexpected (Dwyer) Uncertainty about various aspects of co-ordination (Gregor) Uncertainty about managing emotions of service user/carer (Gregor) Uncertainty (Buckland) Uncertainty about outcomes (Thompson) Fear of the unexpected (Stone) Uncertain risk and consequences (Peay)
Alternatives	Lack of access to records (Haynes) Negotiator and dealmaker with services and service users (Hall) Limited choice (Haynes) Lack of power over resources (Hall; Kinney) Availability of alternatives (Stone; Karban; Brammer) No realistic alternatives (Quirk) Insufficient time to arrange alternative (Quirk) Local operational norms (Quirk) Poor quality of wards (Quirk) Perceived lack of realistic alternatives (Quirk) Out of hours crises more likely to be viewed as requiring detention (Haynes) Principle of least restriction (Stone; Brammer) Substance misuse (Stone) Concordance with medication (Stone) Element of self-control and willingness (Thompson) Delay triggering assessment until all alternatives explored (Quirk; Rooke) Delay deciding (Stone; Skinner)

	Process can take weeks, with difficulty identifying starting point (Quirk) Understanding of mental health and available treatment (Buckland) More willing to explore alternatives if a therapeutic alliance is achieved (Abbott) Whether the person assessed can be trusted to engage (Abbott) Surrender to the view they are suffering from mental disorder (Abbott) Inability of family to cope (Abbott) Feasibility of alternatives (Abbott) Informal vs detention – quicker to access a bed; capacity and dol (Glover-Thomas 2018) Informal viewed as less restrictive (Fistein)

Appendix 4 Participant Information Sheet

Participant Information Sheet

The title of the research project

An Appreciative Inquiry into AMHP decision-making at the point of referral for a Mental Health Act assessment.

Invitation to take part

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the project?

"If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf" (MHA 1983 [as amended 2007], s 13(1)).

This is the statutory basis for the AMHP deciding about whether to proceed with arranging a Mental Health Act assessment for any given individual. Currently there is no research into how AMHPs achieve this, and the code of practice does not offer any guidance to AMHPs with this decision. As AMHPs we are left with forming our own views about when an assessment is required, so this study seeks to bring together a group of AMHPs to find out how this happens. Of central interest are questions like: What influences this decision? How do AMHPs feel about making this decision? How do AMHPs define the positive core of this decision? The research wishes to focus upon the best of what happens now as defined by AMHPs themselves, seeking then to extend the best of now into the future.

Why have I been chosen?

This research seeks to understand a specific AMHP decision from the perspective of the AMHPs who make that decision. Each individual AMHP will have experience of making this decision in their own way and bringing people together to talk about this will help to build a picture from a range of individual perspectives about the positive core of this decision. You have been selected because you are a current practicing AMHP in a substantive post with [retracted] Council.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a participant agreement form.

We want you to understand what participation involves, before you make a decision on whether to participate.

If you or any family member have an on-going relationship with BU or the research team, e.g. as a member of staff, as student or other service user, your decision on whether to take part (or continue to take part) will not affect this relationship in any way. Deciding to take part or not or withdrawing from the study later will not impact adversely on your position, nor in our working relationship. I understand there may be many different reasons for not wanting to participate or wanting to withdraw so please don't feel pressured to take part or fearful of withdrawing.

Can I change my mind about taking part?
Yes, you can stop participating in study activities at any time and without giving a reason.

If I change my mind, what happens to my information?
After you decide to withdraw from the study, we will not collect any further information from or about you.

As regards information we have already collected before this point, your rights to access, change or move that information are limited. This is because we need to manage your information in specific ways in order for the research to be reliable and accurate. Further explanation about this is in the Personal Information section below.

Some personal data will be collected about you during the study and given the workshop format other participants in the workshop will hear your contributions directly, but any contributions you make will be anonymous outside the workshop group. That said your colleagues not involved in the workshops may be able to identify your anonymised contributions from their knowledge of you.

What would taking part involve?
You will be asked to attend three one day workshops a month apart at [retracted location] on the following dates:

Date one from 9.30am to 4.30pm.
Date two from 9.30am to 4.30pm.
Date three from 9.30am to 4.30pm.

Refreshments will be provided. Your attendance will count toward your working hours and you can claim mileage to attend from [retracted] Council.

Ideally those wishing to take part will attend all three sessions, however if you are not able to attend one or more sessions your input would still be appreciated in the workshop(s) you can attend.

The workshops will start with an overview of the research process and why your participation is so vital. A participatory approach is being adopted and so through a mixture small group and whole group discussions, interviews, and creative activities you will shape the design of the study, gather and analyse the data and generate new ideas for the future. You will define the best of AMHP decision-making at the referral stage for a Mental Health Act assessment now, agree a collective dream for the future based on the best of now, and develop a plan of how to implement this dream.

As part of understanding the best of now you will collaboratively decide whether you wish to interview people outside the workshop group. If you decide to do this those interviews will need to take place between workshop one and two.

Following completion of the workshops there will be an opportunity to meet again as a group at a point in time agreed by the group to review what impact the research has had on practice.

What are the advantages and possible disadvantages or risks of taking part?
Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will offer a reflective space to consider your AMHP practice and learn from the experiences of others. Together the workshop seeks to identify the best of practice now and enhance this for the future.

Whilst we do not anticipate any risks to you in taking part in this study, you may find sharing your views and experiences exposing. A basic principle of respect for others will be encouraged in the workshops to reduce the chances of participants feeling criticised.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?
You will be asked to share your experiences of AMHP decision-making at the point of a referral for a Mental Health Act assessment. This study values the experiences of AMHPs in defining the best of their practice. You will be asked to engage in group discussions to identify the best of practice now and develop a vision and implementation plan for the future.

Basic information about you as a participant will also be collected, including your age banding, gender and length of time practicing as an AMHP. These details will help define some basic workshop group characteristics.

Will I be recorded, and how will the recorded media be used?
You will not be recorded during this study.

How will my information be managed ?
Bournemouth University (BU) is the organisation with overall responsibility for this study and the Data Controller of your personal information, which means that we are responsible

for looking after your information and using it appropriately. Research is a task that we perform in the public interest, as part of our core function as a university.

Undertaking this research study involves collecting and/or generating information about you. We manage research data strictly in accordance with:

- Ethical requirements; and
- Current data protection laws. These control use of information about identifiable individuals, but do not apply to anonymous research data: "anonymous" means that we have either removed or not collected any pieces of data or links to other data which identify a specific person as the subject or source of a research result.

BU's Research Participant Privacy Notice sets out more information about how we fulfil our responsibilities as a data controller and about your rights as an individual under the data protection legislation. We ask you to read this Notice so that you can fully understand the basis on which we will process your personal information.

Research data will be used only for the purposes of the study or related uses identified in the Privacy Notice or this Information Sheet. To safeguard your rights in relation to your personal information, we will use the minimum personally-identifiable information possible and control access to that data as described below.

Publication

You will not be able to be identified in any external reports or publications about the research without your specific consent. Otherwise your information will only be included in these materials in an anonymous form, i.e. you will not be identifiable to anyone apart from possibly those colleagues who know you and your views well enough to recognise your anonymous contributions.

The findings will be included in my PhD thesis and will also be put forward for publication in relevant journals. Dissemination will also take place within the [retracted] Council mental health service.

Security and access controls

BU will hold the information we collect about you in hard copy in a secure location and on a BU password protected secure network where held electronically.

Personal information which has not been anonymised will be accessed and used only by appropriate, authorised individuals and when this is necessary for the purposes of the research or another purpose identified in the Privacy Notice. This may include giving access to BU staff or others responsible for monitoring and/or audit of the study, who need to ensure that the research is complying with applicable regulations.

Data about you as a workshop participant will be anonymised through the use of a pseudonym chosen by you at the start of the study. From this point all your contributions will be anonymous. Your name and pseudonym will be recorded together in a secure location and on a BU password protected secure network.

Sharing your personal information with third parties
As well as BU staff [and the BU student] working on the research project, we may also need to share personal information in non-anonymised form with your employer if you raise anything that might be considered a safeguarding matter, or inappropriate conduct such as bullying other workshop members. The workshops will begin with setting fundamental ground rules including respecting the opinions of others to highlight this point.

Further use of your information
The information collected about you may be used in an anonymous form to support other research projects in the future and access to it in this form will not be restricted. It will not be possible for you to be identified from this data.

Retention of research data
Project governance documentation, including copies of signed **participant agreements**: we keep this documentation for a long period after completion of the research, so that we have records of how we conducted the research and who took part. The only personal information in this documentation will be your name and signature, and we will not be able to link this to any anonymised research results.

Research results:

We will keep your personal information in identifiable form for a period of 5 years after completion of the research study. Although published research outputs are anonymised, we need to retain underlying data collected for the study in a non-anonymised form to enable the research to be audited and/or to enable the research findings to be verified.

You can find more specific information about retention periods for personal information in our Privacy Notice.

We keep anonymised research data indefinitely, so that it can be used for other research as described above.

Contact for further information

If you have any questions or would like further information, please contact me at [retracted work email] or on [retracted phone number]. Alternatively, you can contact my University supervisor Mel Hughes at mhughes@bournemouth.ac.uk

In case of complaints
Any concerns about the study should be directed to Matthew Simpson. If you concerns have not been answered by Matthew Simpson you should contact Professor Vanora Hundley, Deputy Dean for Research and Professional Practice, Faculty of Health and Social Sciences, Bournemouth University by email to researchgovernance@bournemouth.ac.uk.

Finally

If you decide to take part, you will be given a copy of the information sheet and a signed participant agreement form to keep.

Thank you for considering taking part in this research project.

Appendix 5 Appreciative Inquiry presentation

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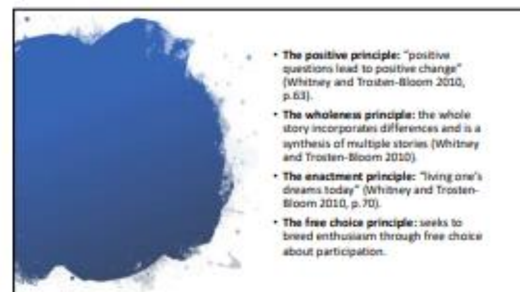

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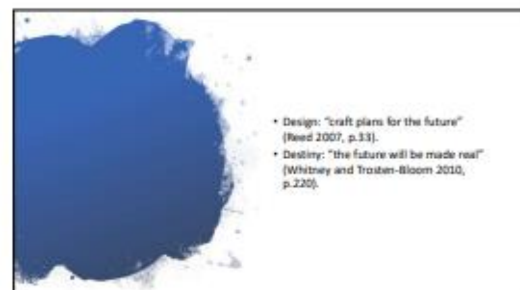

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Appendix 6 Appreciative interview question presentation

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Appendix 7 Amendments to the appreciative interview questions

1. We use our experience, knowledge and the views of others to inform and support our decisions.

a) How do you feel your experience and knowledge has helped you make decisions about whether to carry out a Mental Health Act assessment?

b) What difference does it make when you have support from others? Tell me about an example **where this went well**?

2. Using a holistic and open-minded approach we keep the person at the centre of our decision.

a) **Can you give some positive examples of** how ~~do~~ you keep the person at the centre of the decision about whether to proceed with a Mental Health Act assessment?

b) What does being holistic look like when considering a Mental Health Act assessment?

c) What are the benefits of being open-minded when considering a Mental Health Act assessment?

3. We selectively gather information and think analytically and creatively about possible options and alternatives to an assessment under the Mental Health Act.

a) What creative alternatives to a Mental Health Act assessment might you use?

b) How do you select relevant information?

4. We balance risk and time in our decision-making to create opportunities.

a) **In positive terms**, how does risk **influence** ~~impact upon~~ your decisions about whether to proceed with a Mental Health Act assessment?

b) How can you make positive use of time in your decision-making about whether to proceed with a Mental Health Act assessment?

Appendix 8 Examples supporting mini-interview themes

Theme	Code	Participant	Example
Experience and knowledge	Expertise	Sián	*wealth of experience*
			expertise, not just applying the law
			personal and professional values
		Rhoda	*experience of previous cases*
			similarity even though different
	Experience of risk	Jake	*possible outcomes*
			working with risk
		Jean	*knowing what it's like to sit with high risk in the community*
			unique skills
			years of experience in being able to *take information in* and *unpick risk quickly*
		Edie	hospital admission as a *huge* decision
			unique skills: being able to tolerate risk better than health colleagues
		Charlie	the team were *not reactive*, something they *didn't always do* but had *morphed into it*
	Technical knowledge	Rhoda and Frank	*legal frameworks*
		Jean	*a good underpinning of law*
			options other than admission
		Charlie	*mapping the landscape* which was connected to

			a knowledge of the law and also a knowledge of services and resources.
			navigation to refer to contentious situations
	Knowledge of the person	Edie	*experience of the client*
		Sián, Edie and Jake	Knowledge of the person cited
	A breadth of knowledge	Edie	*broader picture*, a *breadth of knowledge* and a *different set of skills and knowledge*
		Jean and Edie	*unique skills*
	Wider support	Sián and Rhoda	Peer support helpful
		Sián	drawing on the experience of others in the team as a form of support but also to help identify her own gaps in knowledge.
		Rhoda	clarifying her views during these conversations with others, drawing on support and advice from colleagues.
		Sián	*healthy disagreements* and using colleagues as a *sounding board*.
		Edie	*canvassing views* and *getting all angles*, as well as *lively debate with colleagues*
		Sián and Charlie	linked peer support with it being *a lonely place as an AMHP*
		Ro and John	*united front* and a *team approach* as increasing her confidence in her decision-making as an AMHP, adding this made her feel *safe and supported*

		Frank	highlighted lone working as a constraint
Alternatives	Visiting the person referred as part of ‘trying anything’	Charlie, John, Jake, Jean, Rhoda, and Ro	visiting the person referred prior to making a decision about whether an assessment was necessary
		Charlie	being *methodical* and *not rushing in*.
			a *set of brakes*
			establishing facts, and *testing reality*
			not just doing an assessment when asked, and that *when you try everything else it is not a failure* [to go ahead and assess the person under the Mental Health Act]. He wanted to *try to do everything not to detain.*
			creative solutions
		Edie	thinking *analytically and creatively about possible options and alternatives to an assessment.*
		Jean	taking someone onto her caseload to explore alternatives and avoid admission.
		Rhoda	*problem solving*
			trying anything
			seeking *any other way*
		John	emphasis on support from the team
		Jake	*joint visit*
			negotiated down from a request for an MHA assessment.

			negotiating room for manoeuvre to avoid admission
	Assessment as a last resort	Sián	there's *no way this is a Mental Health Act assessment*
			there must be another way
			pull apart why other options didn't work or wouldn't work
			strengths, protective factors and *positives*
			a desire to *get back to what works*.
		Frank	*quick strategy meeting*
Person, holistic, lived experience	Co-construction	Charlie	trying to involve the person and talk about the concerns
			understand and listen to people
			not just [about a] treatment plan and getting people to bend to [our] will
		Rhoda	*choice and capacity*
	A social perspective	Charlie	*what we're here for*
		Edie	*balance to medical model*
		Ro	*think holistically, more about social issues*
		Sián	*think about as a person*
	Moral considerations	Jake	*dealing with a life*
		Sián	*seeing the person as a person*
		Ro, John and Jean	*use of self*
	The harm of admission	Edie	the effects of detention on *employment, family, stigma, side-effects of medication.*

		Rhoda	*doing no harm* and recognising *the harm of admission*
		John	*impact* and *stigma*
		Jake	*least restrictive*
		Ro and Jean	*impact of a Mental Health Act assessment*
Analytical	Interpretation	Charlie	*establishing facts* and *judging how much information we need*, *testing reality* and considering *the agenda of others*.
			interpreting information and *gathering information* as components of being analytical, and a *critical analysis of concerns*
		Edie	*balancing*, *seeing the situation as a whole*, *look[ing] at the effects of admission*.
			getting all angles, *disagreeing with opposing views* and *lively debate*.
			interpreting information
	Harm	Rhoda	*balancing the benefits and harm of hospital*
		Edie	*effects of admission and medication side effects*
			huge decision
		Jean	decision was not taken *lightly*
		John	*stigma of diagnosis*
	Evidence	Jake and Charlie	a professional *over-stating risk on little evidence*
		Sián and Rhoda	*analytical about risk*
			openness to finding *another way*

		Charlie	*being clear of facts*
		John and Jean	described AMHPs as *analytical*
		Jean	risk assessment was based on *evidence*
		Rhoda	bringing *clarity* to decisions
			having a good look at what's going on
		Edie	*facts, but other stuff*
Risk	Thresholds of risk	Charlie	*people have over-inflated concerns*
			AMHP role as providing a *counterbalance to a risk averse culture*
		Edie	being able to *tolerate risk* and so avoid getting *hooked in to a sense of urgency*.
			subjectiveness of risk
			support others with positive risk taking
			risks as *beefed up*
		Jake	*over stated risk on little evidence*
	A balanced view	Jean	*unpick risk quickly*
		Sián	*analytical about risks*
		Rhoda	*clarity* in terms of risk
		John and Ro	*weighing up risk.*
		Edie	AMHP decisions are *risk based*
			AMHPs seek *evidence and experience of risk*
		Jean	she knows *what it's like to sit with risk in the community, being mindful of that*
			positive risk taking
		John and Rhoda	*risk averse referrals*

		Rhoda	recognising the *harm of admission*
			choice and *unwise decisions* when considering risk
		Sián	*looking for strengths and protective factors… positives*
			AMHPs are person-centred and so don't focus on risk
			hoped in the future partner agencies would be *willing to work with risk*
Time	Slowing down	Charlie	being *methodical* and *not rushing in* or being *reactive*.
			slowing the pace
			metaphor of a *set of brakes*
			establishing facts, and *testing reality*
			is *not just doing an assessment when asked*, and that *when you try everything else it is not a failure* [to go ahead and assess the person under the Mental Health Act].
			establish urgency and if there is time to try other things
		Edie	*not just react*[ing], and the need to *stop and take time, don't get hooked in to [a] sense of urgency, say I will think about this*.
			speedily read and interpret information

			needing *time for preparation and to take in the situation*
			slow time for *information gathering, processing and prioritising*
		Jake	*slowing the pace*
		Rhoda	*slowing down the process and having a good look at what's going on*
		Charlie	*pressure to make quick decisions and conclude a process within one day* but that this was a way of working that the team had moved away from.
	Why now?	Jake	*why now?*
		Rhoda	*why today and not yesterday?*
		Sián	*trying to pull apart why other options didn't work and why they won't work now*
			de-escalation, testing alternatives and *information gathering*
	Speeding up	Frank	*time limited* but that this *focussed the mind*
			quick strategy meeting
			a desire for *other services to understand our role better*
		Jean	needing to *unpick risk quickly*
			a desire to convene a *quick mini-conference*
		John	being *decisive* and *getting on with it*
		Ro	*decisiveness*

Appendix 9 Examples supporting appreciative interview themes

Theme	Code	Participant	Example
Experience (professional, personal, expertise) leading to intuition and confidence	Experiential knowledge	Jake	*knowledge of the person, those making the referral, and local resources*
		Edie	knowledge of *mental disorder, treatments, the client and what they need to get better, doctors and staff and their knowledge of risk, resources*
	Intuition and experience	Jake	*general intuition about the situation*
		Charlie	practice changing over the years *due to more experience*
			experience of similar scenarios has been helpful and gives him *confidence in decision-making*
		John	*Having 12 years of AMHP experience I believe helps in my confidence and decision making*
		Frank	built up *a sense of realness of distress*
			ability to *recognise patterns leading to crisis… predictable triggers… familiar themes* which he said *links to intuition*
			experience of a range of client groups over the years
			when [he] started out decisions were

			terrifying, but that he has *become more robust and confident*
		Jean	having *worked across most areas of mental health over [the] years, [building] knowledge and experience of what can be done in hospital and in [the] community*
			after *many years working in mental health you know when to do [an] MHA assessment*
			her *knowledge and experience enables [her] to balance a lot of information (resources, law, what works and doesn't) very quickly, and gives [her] confidence to make that decision*
	Risk threshold	Ro	*experience in Assertive Outreach helped [her] to manage risk [and gave her a] higher risk threshold*
		Edie	has become *more tolerant of risk with experience*
	The personal domain	Ro	the *suicide of [a] close family member*
		Rhoda	*law embedded after course* and then *life experience… layered on top*
		Sián	*10 years practice* in a *different area of law* and how she has *got to know a lot about people and law*

Peer/team support as a resource	Moral support	Jake	*moral support in an otherwise hostile environment*
	Peer support	Jake	*someone to chew it over with* and *to discuss the criteria, grounds, best interests side.*
		Charlie	team support as helpful
		Edie	*consulting others is helpful…[and] enriches the assessment and decision making*
	Specialist knowledge	Edie	involving people with specialist knowledge of *CAMHS [child and adolescent mental health], dementia, ASD [autistic spectrum disorder] or [a] person who knows the person well*
			these elements allow for *positive risk*
		Frank	*Great to bounce off ideas, particularly where [a] colleague has expertise in a particular field… [or] a greater depth of understanding*
			an *ability to ask any questions [and] won't be ridiculed*
		Sián	drawing on colleagues' *past experiences* and the benefit of *talking through scenarios*
	Validation	Jean	a *way of checking my thoughts [are] not completely off beam, especially when being*

			hounded to assess whilst knowing [it's] the wrong thing to do
			Support *gives me confidence to make particularly contentious and unpopular decisions*
	Emotional support	John	*just knowing that others will make themselves available is gratefully appreciated*
		Ro	peer support is *helpful with some colleagues whose practice I respect*
			emotional support in the face of a *bullying consultant [psychiatrist]*
		Rhoda	team support as a *sounding board*
			helpful even from the perspective of gaining *moral support*.
	Support from partner agencies	Charlie	support from partner agencies
			possible *to focus on the person and not team dynamics*
		Sián	*relationships with other teams [are] pivotal*
			importance of developing a *shared understanding*
			talking with doctors in a collaborative way to enable others to *reach their own conclusion*
			supportive work with others was a way to

			manage [the] expectations of others
		Frank	*Consultants that [I] have [a] good working relationship over the years. [I] can talk through [and build a] shared responsibility regarding risk, agree [an] approach to [the] referral*
Focus on essence and uniqueness (identity) of person	Understanding attitudes to treatment	Edie	the person's *wishes and views of admission. Their values come into that. Their way of life*
			HRA Article 3, degrading treatment, dignity, anti-depot, pinned down, injection is poison
			if a person has strong views against psychiatric treatment, perhaps preferring to live with symptoms, that she would *bear this in mind* as they might view the treatment as torture
	Understanding the life the person has lived	Jake	*best interests in [the] context of all the information*
		Charlie	*being holistic. What's going on for the person which might be affecting the situation*
		Rhoda	*see[ing] [the person referred] as [a] person, not just [a] demographic and [a] diagnosis*

			wanted to know the person's *past experiences… what their wishes were*
			alternatives to assessment and admission would be *very individual to each person*
		Sián	*person as an individual rather than [a] set of risk factors and [a] diagnosis*
			to know about them *as a person… with a life*
			strengths based not deficit based
			someone referred to her who *had been [a] film-maker [and] won awards for [their] work…* this information appeared *somewhat irrelevant but somehow help[ed]*
			not about legal thresholds [but was] subjective to the person
			need to *understand what dignity means [to them] and what distress means*
	Establishing a baseline	Frank	*what is the person normally like?*
			understand them when they are well
			sometimes risk is part of who the person is
			then start to consider what has changed. What is going on in their lives? What are

			the barriers to dealing with difficulties and consider what solutions there may be
			looking at [the] landscape of [a person's] life and history, everything they are
			identifying landmarks in people's lives
	Connecting with the person	Jean	*looked at [the] information and took [the person] onto [her] caseload*
			routine and familiarity [were] important
			when I know [the] client so well that I know admission would not benefit [them].
Listening to person and others	Establishing current wishes	Jake	*listens to [the referred person's] wishes [and] feelings* and *ditto relatives*
			discuss alternatives with them
		Charlie	*what concerns the person or the family…. Ask the person what's the problem for them*
			part of the referral information is information provided by the service user
		Edie	*trusting people and giving them options*
		Frank	*talking to the person before the assessment* and

			valuing people are experts in themselves.
		Edie	understanding the person's *views about admission*, their *values* and their *lifestyle*.
			listening to them and giving them time
			unwise decisions, giving an example of extreme sports and *do they like to live dangerously?*
			past and present wishes
		Ro	*talking directly to [the] person and say to them what do you want?*
		Rhoda	listen to *what [the person referred] is saying now* and *what [are the] views of [the] family?*
		Sián	wanting to *unpick what is going on with that person, why [they don't] want to engage, what does it mean to them*
		John	*naturally consider[s] the impact this request could or would have for the patient; their own distress, differing views, family and friends' perspectives.* She later said she *pay[s] due regard to talking to any relevant others that may know the patient well.*

	Establishing past wishes	Charlie	ascertain *past attitude to treatment…* AMHPs *can learn from family about this*
		Frank	*speak to people who know the person* in order to *understand them when they are well.*
		Sián	*capacity… [a need to] understand whether by choice or not*
		Edie	*consider family and friends*, as well as the need to *consult with professionals with knowledge of the situation* and to gather *information from people who know about specialisms*
		Frank	*conversations with key people [including] family*
		Ro	speaking to *anyone… that has been involved*
Transparency		Jake	*looking at different paths [and] scenario's with [people referred].*
		Charlie	*sharing the concern and possibilities with the service user*
			trying to have a conversation with people, why we are considering [assessment] what might be the next step
			transparency and went on to say AMHPs *properly*

			explore [the] option of people coming into hospital and allow them to make a decision.
			don't say if you don't mean
		Edie	*being transparent with the person explaining the concerns of the service*
			recommend giving due warning of possible outcomes
		Sián	it is *interesting to compare to child protection services, [where professionals] always have to explain [the] consequences to [the] person and have frank conversations.*
			parallel to [the] Mental Capacity Act also, and how under the *Mental Health Act [it] is too easy to deprive people of [their] liberty without due process*
			sometimes people are taken unawares [about] concerns and *this is worrying*
			using a joint visit as a way to *highlight concerns to people,* reflecting often *people [are] not given current information to make [a] choice*
			A joint visit and transparency can *facilitate home*

			treatment and social care involvement, including *exploring what the barriers are to engagement* and often that *people worry talking about concerns will increase risks*
		Frank	*openness about the process* and an *openness with family*
			need to have an *honest discussion with [the] person*
			it may be important *to accept risks*
Focus on social perspectives		Jake	being *not just looking at the criteria, risk etc… not just the medical model. Looking at context,* including their *support network*
			use the person's *own network to support* and therefore *avoid admission*
			person's *own motivations*
			admission might be more harmful
		Edie	the *effect of admission. What would that do to them?*
		Charlie	*social stress factors we might be able to affect and avert the need for assessment*
			yes [they] might have a diagnosis and are not taking medication, but is there anything else

			we can do to support?
		Frank	*lots of injustices in society,* and the importance of *recognising [the] impact of these issues… abusive relationships, financial stress etc…*
		Edie	AMHPs consider *everything we may look at in a Care Act assessment*.
			need to explore the *whole current life of the person*, including *family situation, social supporters, employment, age and physical disabilities, cultural differences*
			being different doesn't equate to mental disorder
		Jean	*look at social options available,* including *what's worked or not*
			environment… bereavement, job loss.
			exploring care management options as a way to *swerve hospital*
		Sián	the *person as an individual… [including] protective factors, family, living circumstances.*
			decisions would be *individual to the person [and that] what might be relevant to one*

			[person] might not be [relevant] to another
			assessment [in a] care home where what was needed was a *change of placement but no one [other placement] accepting [the person] due to [their] behaviour*
			ability to influence situations if there are other solutions, i.e. change [of] care home
		Rhoda	*psychiatry [is] new, people would have always had illness but society [has] changed [its] views regarding mental disorder*
			cure through the medium of dance
			fixed delusions [about] God talking but [the person was] happy so no need to treat
			social issues, environmental issues, financial issues, Maslow's hierarchy of needs: [the] basics need to be right
Seeing people through different lenses	Openness	Frank	*look[ing] at individual[s] through different lenses; medical, psychosocial, psychodynamic.*
			open to interpretations
		Jake	*MDT [multi-disciplinary team]*

			approach to solve issues
		Sián	*open to new/different information… encourages you to explore detail*
			sometimes one piece of information can be definitive / changes [the] situation on its head
		Rhoda	*open minded*
			psychiatry [is] new and her emphasis would be to *try not to impose [treatment]*
			being *holistic* and avoiding *one person's agenda*
	Scepticism	Frank	*often a mismatch in person to on paper [in that things are] not as bad as [they] seem on paper*
		Charlie	*starting point is scepticism, critical of the request, surely there must be something else that can be done*.
			other's views can be distorted
			the potential to change his mind if detention is necessary
			viewing the situation through a critical lens, but ultimately being open to detention as *the last resort on the list*

Balanced view of outcomes	Recognising the harm of admission	Jake	*a situation where the risks are moderate but [the person] would hate being detained and admission might be more harmful*
		Charlie	considering *if treatment is worse than letting be*
			considering *the pros and cons of doing an assessment*
		Edie	the *effect of admission. What would that do to them? Distress to the person. Distress to carers.*
			the *effects on close people and what they would say – can they handle it?*
			the *risk of admission and detention and treatment in hospital*
			often *the distress of the person is overlooked and not seen as a risk*
		John	*the impact this request could or would have for the patient.*
		Frank	*acknowledging [the] implications of [an] assessment*
			joint visit with the crisis team and *gain[ed] agreement for [a] more stable pathway*
		Jean	*will we escalate risk by such [a] heavy handed intervention?*

		Frank	*when admission just offers containment but doesn't improve [the] situation*
	Finding consensus	Rhoda	understanding the person's *views on meds [medication],* including a recognition of the *impact of meds, side effects*
			trying not to impose
		Sián	*strengths-based perspective, look[ing] for protective factors to balance risk*
		Ro	*at times an MHA assessment can draw a line and needn't be unpleasant*
Open to all possibilities	A neutral stance	Sián	*open to different forms of information and weighing it appropriately*
			more holistic than if you are fixed based on previous experience
			encourages you to explore detail
		Rhoda	a *blank sheet rather than one person's agenda* and she framed being open minded as being *holistic*
			no assumptions at the start and gather information to develop [a] picture
		Ro	*not being attached to an outcome*
		John	*comfortable in accepting outcomes will naturally evolve*

			so long as I remain calm and open-minded
		Jean	avoid making a decision *prior to obtaining the information*
	A cautious stance	Jean	possibility for the situation to be *over-egged*, or conversely that *some people underplay [the] situation*
			maintaining an open mind *enables us to make [the] best decision we're able to without it being loaded*
		Charlie	*being open minded* in the context that treatment could be worse
			detaining is sometimes necessary and that is keeping the person at the centre. Start from the point that surely there must be something else that can be done
	Open to being wrong	Edie	*being able to be receptive to all information* and *being open to and changing minds /surprised – open to being wrong*
		Frank	a *sense of [my] own prejudices, biases, intolerances. Knowing [I am] not always right [and] not fall[ing] into [the] trap of [thinking I have] seen this*

			before. Things are never the same.
	Pragmatism	Frank	*positive approach [to] what works [and] what doesn't*
			when admission just offers containment but doesn't improve [the person's] situation
		Jake	*more creative work* in the context of being open-minded
Collaboration with services/family	The views of the family	Jake	exploring *different paths [and] scenario's* with people referred and their relatives, and *listening to their wishes and feelings*
		Rhoda	seeking the *views of the family*
		Edie	*involving wider family,* the *effects on close people and what they would say*.
		Charlie	*contacting family [to see if] they can offer solutions*
	Shared accountability	Frank	*shared responsibility regarding risk* with consultant psychiatrists, seeking to *agree [an] approach to [the] referral*
		Charlie	*sharing decisions* with other teams
		Edie	*consult[ing] professionals with knowledge of the situation* as well as gaining *information from people who know about specialisms.*

		Jean	*a lot of joint working with [the] specialist dementia nurse* as part of exploring alternatives to an MHA assessment
		Rhoda	the benefit of a *blue light meeting*
	Managing the anxiety of others	Frank	*conversations with key people [including] professionals and family*
			acknowledging [the] distress [of the referrer], the need for *validation of [their] concerns… [and a] genuine acknowledgement of [the referrer's] concern*
			invest[ing] time to listen to [the] anxiety of [the] referrer.
	Relationships	Sián	*relationships with other teams [are] pivotal*
			developing good relationships with people [and] teasing out less restrictive options
			sharing not abdicating responsibility
Shared understanding with the person		Edie	understand the person's *values* and their *way of life*
			someone whose *flat [was] chaotic but in her world this isn't bad*.
			trusting people and giving them options, but equally *being transparent with*

			[the] person, explaining the concerns of the service
		Charlie	having *conversations with people* and asking *what's the problem for them*.
			sharing the concern and possibilities with the service user.
		Rhoda	understand *what [the person's] wishes were, what [they] are now,* their *views [about] meds*
		Frank	*valuing people are experts in themselves*
		Jake	*listening to [the person's] wishes and feelings*
		Sián	*understanding whether [their decisions were] by choice or not*
			joint visit to *highlight concerns to people.*
Joint visit	A personal connection	Ro	*triage visit*
		Jake	*listening to [the person's] wishes and feelings* and discussing *different scenarios with them*.
		Charlie	an *advance visit beforehand* in order to establish *information provided by the service user*
		Frank	a *joint visit with the crisis team,* particularly *where information doesn't stack up*

		John	*it can be helpful and complementary in decision making to have the opportunity to visit the patient before any assessment is convened*
	For transparency	Edie	*joint assessment or alone/social work colleague with a view to being transparent with the person explaining concerns of the service… and giving due warning of possible outcomes*.
		Sián	*sometimes people are taken unawares [about] the concerns* and so the joint visit is a way to *highlight concerns to people*.
	To explore alternatives	Edie	*the person need[ing a] Care Act assessment - landing on [my] caseload*
			explore *housing, social care package, can the family stay, can someone leave if at risk*
		Jean	*joint working with the dementia nurse*
			took [the person] onto [her] caseload
		Sián	joint visit as a way of *working together [and being] collaborative* with other services
			sharing not abdicating responsibility
			focus on transparency was to

			facilitate home treatment and social care involvement, as well as *explore what the barriers are to engagement*
			joint visit *can create opportunities to find out information… [and] provide evidence for if [an] assessment [is] needed or not.*
			trying to avoid [detention under the] MHA if possible
Documentation/opinion subject to verification		Jake	knowledge of the person requesting the assessment and whether they are someone who tends to *panic* or *give up easily*
			risks are often presented as higher by [NHS Trust] staff
		Charlie	being *critical of the request* and he felt *other's views can be distorted*
		Edie	*checking reliability* of information, and she suggested *risks are exaggerated by Health [staff]*
		Jean	*review everything* and *corroborate information*
			importance of *knowing [the] sources of information; reliability among mental health staff; understanding [the] motivation of [the] person giving [the]*

			information: do they have [an] agenda?
		John	*information at the start can be weighted in offloading risk*
		Rhoda	*blank sheet rather than one person's agenda*
			asked *what are the actual risks?*
		Frank	*where information doesn't stack up*
			the *anxiety of the referrer*
			people are *not as bad as [they] seem on paper*
Analysis of risk/protective factors	Strengths	Sián	considered risk from a *strengths-based perspective*, and she would *look for protective factors to balance risk*
		Frank	*tease out what has worked and what hasn't*
	Gaining clarity through criticality	Sián	*likelihood and severity* of risks, and emphasised the need to *analyse rather than accept at face value*
		Charlie	*often we can reduce concerns by analysing the information*
			understanding the risk clearly and being able to *unpick risk*.
		Rhoda	establish *actual risks* and *immediate risk and likelihood*
		Frank	a *mismatch in person to on paper*

		Jake	risks are often represented *in historical terms rather than actual current risk.*
		Frank	AMHP as the person *who challenges the level of risk,* and that risks *are often presented as higher*
			admission might be more harmful
Acceptance/tolerance of risk/positive risk taking		Frank	a *positive risk view*
			services *may need to accept risks* and that *sometimes risk is part of who the person is*.
		Edie	risks needing to be *proportionate*
			more *positive risk taking* and said *I'm getting better at it*
		John	*positive risk taking approach*
		Frank	*when admission just offers containment but doesn't improve [the] situation,* and *trying to influence risks in other ways*
Changing gears and buying time	Time to gather information	Rhoda	*actual risks* and *immediate risk and likelihood*
			the request for an MHA assessment *doesn't always need an immediate response*
			time to gather information
		Jake	trying to *slow it down* and *buy time to properly look at the*

			circumstances, the mindset of the referrers and the alternatives available. Time to properly collate information, not be rushed to assess and risk a knee jerk reaction
	Time for consideration	Edie	*time to explore and gather, assimilate and process information*
		Rhoda	desire to *create time to have [a] more considered response*
	Time to explore alternatives	Charlie	*positive use of time is trying to create more time…. More space to try alternatives…. Space to do something different*
		Frank	*diplomatic flu…* a need to *acknowledge distress and risks but explain [I] need time to consider*.
			pathway to assessment that can alleviate [the] crisis and how if you *put in other help and support [this can] avert [the] need for [an] assessment*
			slowing [the] response down… rushing leads to the *worst assessments*
			Build in time and often the crisis passes…. [That it is] *amazing how often things resolve.*
		Sián	there *can be a short window to ascertain*

			certain things, but that *delaying things [allows time] to gather more information*
			someone *agreeing to informal [voluntary admission to hospital] within hours of [Sián] declining to assess.*
		Jean	need to *balance [the] speed of response with the need for further information*
			sometimes a faster response will be required *because of risk*

Appendix 10 Covid update participant information

Participant Information Sheet

The title of the research project

An Appreciative Inquiry into AMHP decision-making at the point of referral for a Mental Health Act assessment.

Invitation to take part

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the project?

"If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf" (MHA 1983 [as amended 2007], s 13(1)).

This is the statutory basis for the AMHP deciding about whether to proceed with arranging a Mental Health Act assessment for any given individual. Currently there is no research into how AMHPs achieve this, and the code of practice does not offer any guidance to AMHPs with this decision. As AMHPs we are left with forming our own views about when an assessment is required, so this study seeks to bring together a group of AMHPs to find out how this happens. Of central interest are questions like: What influences this decision? How do AMHPs feel about making this decision? How do AMHPs define the positive core of this decision? The research wishes to focus upon the best of what happens now as defined by AMHPs themselves, seeking then to extend the best of now into the future.

Why have I been chosen?

This research seeks to understand a specific AMHP decision from the perspective of the AMHPs who make that decision. Each individual AMHP will have experience of making this decision in their own way and bringing people together to talk about this will help to build a picture from a range of individual perspectives about the positive core of this decision. You have been selected because you are a current practicing AMHP in a substantive post with [retracted] Council.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a participant agreement form.

We want you to understand what participation involves, before you make a decision on whether to participate.

If you or any family member have an on-going relationship with BU or the research team, e.g. as a member of staff, as student or other service user, your decision on whether to take part (or continue to take part) will not affect this relationship in any way. Deciding to take part or not or withdrawing from the study later will not impact adversely on your position, nor in our working relationship. I understand there may be many different reasons for not wanting to participate or wanting to withdraw so please don't feel pressured to take part or fearful of withdrawing.

Can I change my mind about taking part?
Yes, you can stop participating in study activities at any time and without giving a reason.

If I change my mind, what happens to my information?
After you decide to withdraw from the study, we will not collect any further information from or about you.

As regards information we have already collected before this point, your rights to access, change or move that information are limited. This is because we need to manage your information in specific ways in order for the research to be reliable and accurate. Further explanation about this is in the Personal Information section below.

Some personal data will be collected about you during the study and given the workshop format other participants in the workshop will hear your contributions directly, but any contributions you make will be anonymous outside the workshop group. That said your colleagues not involved in the workshops may be able to identify your anonymised contributions from their knowledge of you.

What would taking part involve?

You will be asked to attend three one day workshops a month apart at [retracted location] on the following dates:

Tuesday 29th September 2020 from 9.30am to 4.30pm.
Tuesday 3rd November 2020 from 9.30am to 4.30pm.
Wednesday 25th November 2020 from 9.30am to 4.30pm.

Refreshments will be provided. Your attendance will count toward your working hours and you can claim mileage to attend from [retracted] Council.

Ideally those wishing to take part will attend all three sessions, however if you are not able to attend one or more sessions your input would still be appreciated in the workshop(s) you can attend.

The workshops will start with an overview of the research process and why your participation is so vital. A participatory approach is being adopted and so through a mixture small group and whole group discussions, interviews, and creative activities you will shape the design of the study, gather and analyse the data and generate new ideas for the future. You will define the best of AMHP decision-making at the referral stage for a Mental Health Act assessment now, agree a collective dream for the future based on the best of now, and develop a plan of how to implement this dream.

As part of understanding the best of now you will collaboratively decide whether you wish to interview people outside the workshop group. If you decide to do this those interviews will need to take place between workshop one and two.

Following completion of the workshops there will be an opportunity to meet again as a group at a point in time agreed by the group to review what impact the research has had on practice.

Covid-19 update: Some of the above may be moved to an online videoconferencing platform if this becomes necessary or appropriate due to the Covid-19 pandemic. If this is the case the number and duration of workshop sessions may change. If you are asked to participate online the meetings will be by invitation only and a password for access will be used to ensure privacy. Regular breaks will be offered and participants themselves will be able to influence when these breaks occur and the overall duration of any online sessions. Online sessions will not be recorded. I will ask you to join using your camera so you can be seen during the session to enhance the communication experience. If you experience any distress while using this format, I would ask you send me a private message and I will at the earliest opportunity contact you separately for an individual discussion during a break. If you absent yourself from the meeting at any point I would ask that you let me know if you want me to contact you.

What are the advantages and possible disadvantages or risks of taking part?
Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will offer a reflective space to consider your AMHP practice and learn from the experiences of others. Together the workshop seeks to identify the best of practice now and enhance this for the future.

Whilst we do not anticipate any risks to you in taking part in this study, you may find sharing your views and experiences exposing. A basic principle of respect for others will be encouraged in the workshops to reduce the chances of participants feeling criticised.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?
You will be asked to share your experiences of AMHP decision-making at the point of a referral for a Mental Health Act assessment. This study values the experiences of AMHPs in defining the best of their practice. You will be asked to engage in group discussions to

identify the best of practice now and develop a vision and implementation plan for the future.

Basic information about you as a participant will also be collected, including your age banding, gender and length of time practicing as an AMHP. These details will help define some basic workshop group characteristics.

Will I be recorded, and how will the recorded media be used?

You will not be recorded during this study.

How will my information be managed ?

Bournemouth University (BU) is the organisation with overall responsibility for this study and the Data Controller of your personal information, which means that we are responsible for looking after your information and using it appropriately. Research is a task that we perform in the public interest, as part of our core function as a university.

Undertaking this research study involves collecting and/or generating information about you. We manage research data strictly in accordance with:

- Ethical requirements; and
- Current data protection laws. These control use of information about identifiable individuals, but do not apply to anonymous research data: "anonymous" means that we have either removed or not collected any pieces of data or links to other data which identify a specific person as the subject or source of a research result.

BU's Research Participant Privacy Notice sets out more information about how we fulfil our responsibilities as a data controller and about your rights as an individual under the data protection legislation. We ask you to read this Notice so that you can fully understand the basis on which we will process your personal information.

Research data will be used only for the purposes of the study or related uses identified in the Privacy Notice or this Information Sheet. To safeguard your rights in relation to your personal information, we will use the minimum personally-identifiable information possible and control access to that data as described below.

Publication

You will not be able to be identified in any external reports or publications about the research without your specific consent. Otherwise your information will only be included in these materials in an anonymous form, i.e. you will not be identifiable to anyone apart from possibly those colleagues who know you and your views well enough to recognise your anonymous contributions.

The findings will be included in my PhD thesis and will also be put forward for publication in relevant journals. Dissemination will also take place within the [retracted] Council mental health service.

Security and access controls

BU will hold the information we collect about you in hard copy in a secure location and on a BU password protected secure network where held electronically.

Personal information which has not been anonymised will be accessed and used only by appropriate, authorised individuals and when this is necessary for the purposes of the research or another purpose identified in the Privacy Notice. This may include giving access to BU staff or others responsible for monitoring and/or audit of the study, who need to ensure that the research is complying with applicable regulations.

Data about you as a workshop participant will be anonymised through the use of a pseudonym chosen by you at the start of the study. From this point all your contributions will be anonymous. Your name and pseudonym will be recorded together in a secure location and on a BU password protected secure network.

Access to online platform for participation if required will be by invitation only and a password for access will be used to ensure privacy.

Sharing your personal information with third parties
As well as BU staff [and the BU student] working on the research project, we may also need to share personal information in non-anonymised form with your employer if you raise anything that might be considered a safeguarding matter, or inappropriate conduct such as bullying other workshop members. The workshops will begin with setting fundamental ground rules including respecting the opinions of others to highlight this point.

Further use of your information
The information collected about you may be used in an anonymous form to support other research projects in the future and access to it in this form will not be restricted. It will not be possible for you to be identified from this data.

Retention of research data
Project governance documentation, including copies of signed **participant agreements**: we keep this documentation for a long period after completion of the research, so that we have records of how we conducted the research and who took part. The only personal information in this documentation will be your name and signature, and we will not be able to link this to any anonymised research results.

Research results:

We will keep your personal information in identifiable form for a period of 5 years after completion of the research study. Although published research outputs are anonymised, we need to retain underlying data collected for the study in a non-anonymised form to enable the research to be audited and/or to enable the research findings to be verified.

You can find more specific information about retention periods for personal information in our Privacy Notice.

We keep anonymised research data indefinitely, so that it can be used for other research as described above.

Contact for further information

If you have any questions or would like further information, please contact me at [retracted work email] or on [retracted work phone number]. Alternatively, you can contact my University supervisor Mel Hughes at mhughes@bournemouth.ac.uk

In case of complaints

Any concerns about the study should be directed to Matthew Simpson. If you concerns have not been answered by Matthew Simpson you should contact Professor Vanora Hundley, Deputy Dean for Research and Professional Practice, Faculty of Health and Social Sciences, Bournemouth University by email to researchgovernance@bournemouth.ac.uk.

Finally

If you decide to take part, you will be given a copy of the information sheet and a signed participant agreement form to keep.

Thank you for considering taking part in this research project.