

APPROVED MENTAL HEALTH PROFESSIONALS AND DETENTION: AN EXPLORATION OF PROFESSIONAL DIFFERENCES AND SIMILARITIES

Abstract

The enactment of the Mental Health Act (MHA)2007 introduced the role of the multi-disciplinary Approved Mental Health Professional (AMHP) in England and Wales by amending The MHA 1983. The role can now be performed by a range of professionals including a, psychologist, occupational-therapist, social worker or mental-health/learning difficulties nurse. This amendment amongst other legal provisions replaced the earlier Approved Social Worker role. This is an exploratory qualitative research that aimed to identify if the decision-making relating to management and assessment of risk varied according to the professional background of the AMHP. The decision-making of ten social work and ten nursing AMHPs were examined through the use of an experimental vignette containing audio-visual and written materials in order for participants to reach a decision about whether or not to detain. Proposed detention rates between social work and nurse AMHPs were identical although variation was found across the whole sample in terms of the risks that were identified in the vignette. The paper concludes by arguing that these results suggest that differences in the way AMHPs reach decisions may well relate to a variety of individual differences rather than reflecting initial professional identity and training as so often argued in the literature.

Key words: Decision, AMHP, ASW, Admission, Risk, MHA, Detained.

Introduction

Professional role changes within mental health systems and structures are not new. Society has long struggled with how to manage an effective mental health system (Glover-Thomas

2002). These struggles have influenced which professionals are mandated to be involved in detaining decisions for compulsory assessment and treatment. In recent times in England and Wales the Approved Social Worker (ASW) under the Mental Health Act (MHA) 1983 had the ultimate decision in deciding whether a person was detained or not. When this role was converted to the Approved Mental Health Professional (AMHP) under MHA 2007 it enabled a broader range of eligible professionals (occupational therapists, chartered clinical psychologists, social workers and mental health/learning disability nurses) to make that detention decision once they have completed a post-graduate AMHP course. The result is that this wider professional group are now empowered to be AMHPs and make the detention decision which occurs at the conclusion of a mental health act assessment. The decision to detain the assessed person (by making an application for admission¹ when founded upon medical recommendations) should only be made when alternative less restrictive options in the community have been discounted. Less restrictive options would include engaging an NHS mental health crisis team to offer community treatment and support (not community treatment orders) as an alternative to hospital admission (See table 1.0). This paper explores whether these decisions differ according to the professional background of the AMHP, by drawing on research that explores which AMHPs are most likely to make a decision to detain.

Previous studies

What we know in respect of this type of decision making can be found in two comparative studies relating to ASWs or AMHPs. The former can be found in a study by Peay (2003) and the latter by Bressington, Wells and Graham (2011). The work of Peay (2003) was the first study to gather data on the decision making of ASWs. Using a vignette of written and visual-audio material (RCPSYCH 1997) the study found differing decisions being made on the same

¹ The AMHP does have the power to detain (founded upon medical recommendations) under Sec 4 MHA (up to 72 hours in an emergency), Sec 2 MHA (up to 28 days for assessment followed by treatment as needed) or Section 3 MHA (up to 6 months for treatment) depending upon the circumstances and treatment plans.

case between ASW participants. Forty ASWs were asked the identical question, ‘as the ASW, what would you do next?’ after considering the vignette. Evidence emerged of inconsistent decision making amongst the ASWs and highlighted the complexity of the situations often faced by those making detention decisions.

The later comparative study by Bressington, Wells and Graham (2011) found that although professionals from differing backgrounds enter AMHP training with varying mental health knowledge, the impact of the course by the time of completion leaves a high level of harmonisation between professions including a shared understanding of the AMHP role and the social perspective in mental health. (see also Bowers, Clark and Callaghan 2003; Coffey & Hannigan 2013; Holmes 2002 and Knott and Bannigan 2013). The studies by Peay (2003) and Bressington, Wells and Graham (2011) underline that differences between AMHPs are less likely to be notable than is often claimed and indicate that further research is required.

What we know about the decision making of AMHPs (and previously ASWs) as with other professionals involved in mental health services is that there is a strong emphasis upon the assessment and management of risk, and this is reinforced by the language used in the MHA². In this sense the AMHP’s decisions can be seen as ‘risk work’, as balancing the need for ‘risk-taking’ and ‘risk minimisation’ (Davies 1996) through predictive approaches. However, as Coffey & Cohen et al (2017) suggests this legitimised work of professionals to assess risk, can be seen as a form of ‘fiction’ due to poor predictive ability and a fear of consequences leading to risk adverse options being considered. This can in turn means that the wish of society to see the effective management of these mental health risks (Langan and Lindow 2004) is only at best aspirational. Furthermore, we know that the term ‘risk’ may not be understood by service users who may be unaware that risk assessment is a key professional

² Each assessment must consider ‘risk to their own health’, ‘risk to their own safety’ and for the ‘protection of others’.

mental health function over which they may have little influence (Langan and Lindow 2004, Dixon 2012). Therefore, each AMHP has the complex challenge of how best to balance risk, rights and responsibilities of all concerned when s/he seeks to avoid undesirable outcomes.

Methods

Ethical approval was initially gained through the School for Policy Studies Research Ethics Committee and sponsored by Research and Enterprise Development within the University of Bristol. Ethical approval was then gained through either local government research governance and/or through NHS Research and Development departments depending on the local arrangements for each site. Local ethical governance arrangements differed between research sites depending upon whether the local authority and NHS mental health services were integrated. In addition, Association of Directors of Adult Social Services (ADASS) screening and Integrated Research Application System (IRAS) approval was required on two research sites. The professional role of the researcher also required that the British Association of Social Workers Codes of Practice (BASW 2012) and Health Care Professionals Council (HCPC 2008) ethical codes were adhered to.

Research sample

A purposeful non-probability sampling technique was adopted (Gilbert 2008) due to the lack of centralised national registration and records of AMHPs or their professional backgrounds. Each local authority must employ AMHPs, and those known to employ nurse AMHPs were approached in turn first for ethical approval, assisted by information held by the AMHP Leads Network (Bogg 2011).

Twenty participants were recruited to meet a quota of 10 social work AMHPs and 10 non-social work AMHPs (from any eligible profession). The study recruited 10 social work

AMHPs and 10 nurse AMHPs, as no Occupational Therapist or Psychology AMHPs responded to the call sent out by the local AMHP leads. Only AMHPs who were practicing were recruited, via the AMHP lead acting as introducer. Participants who opted in to the study gave their informed consent to the researcher before taking part.

The gender distribution between male and female participants was 4 and 6 for social work AMHPs and 3 and 7 for nurse AMHPs. The range of practice experience across groups started as early as 1977 for social work AMHPs and as late as 2009 for nurse AMHPs. The majority of social work AMHP participants converted to AMHPs from being an ASW (7 participants) with the remainder becoming an AMHP from qualification (3 participants). There were four social work AMHP participants who had trained before 2000, one had practiced under the 1959 MHA and the other 3 post the 1983 MHA. The majority of nursing AMHPs had started practicing in that role between 2010 and 2012 (8 participants). The age range of the participants was, 30-39 (2 social workers and 1 nurse), 40-49 (4 social workers and 7 nurses), 50-59 (1 social worker and 2 nurses) and 60-65 (3 social workers and 0 nurses). The ethnicity of the participants was not captured.

Each of the 20 participants (across 6 sites) engaged with a face to face 1:1 semi-structured interview lasting approximately ninety minutes, using an interview schedule covering the relevant topics to be explored. Contained within each interview was the vignette which was seen as a valuable methodology for gaining qualitative data and approaching realistic topics such as a mental health act assessment (Barter & Reynold 1999; Jenkins & Bloor et al 2010; Taylor 2006). This vignette method draws on the approach undertaken by Peay (2003) in the earlier study outlined above.

Participants were questioned about their AMHP practice and the risks they observed in the vignette. This vignette articulated the case history and current presentation of a black Afro-

Caribbean male referred to as Mr Anderson, who lived alone with a history of mental health and social economic difficulties. There had been a history of mixed engagement with social care and health services and neighbours had become concerned with his current behaviour and initiated a mental health act assessment via a GP phone call. The vignette contained an AMHP referral (dated the day of the interview) requesting the MHA assessment and was accompanied by fabricated NHS and social care clinical letters, records and reports which gave an up-to-date history at the point of the referral of Mr Anderson. After the participants had read these materials and made notes, they were shown a video of Mr Anderson being assessed at home, after which Mr Anderson told the assessing team to leave. Participants were then asked “as the AMHP, what would you do next?” Supplementary, follow-up questions were asked to explore their answers more fully.

Pilots of the vignette and the interview schedule assisted in ensuring that the research tools were fit for purpose using different participants to those of the main study. Pilot participants highlighted the reality of the vignette as a strength, particularly as they had personal experience of the situation in the vignette (Barter & Reynold 1999). The pilot participants were originally asked ‘what section of MHA would you now use’ after having watched the video. This was altered to ‘as the AMHP, what would you do next?’, allowing the participants to more fully explain their decision making and gave an opportunity for the research to ask follow-up questions.

Research Findings

The data was audio recorded and professionally transcribed. Using Nvivo 10 the researcher coded the data to generate themes which is a widely accepted form of analysis for qualitative studies to enable distinct themes to emerge through sound analysis (Braun & Clarke 2006). To illustrate the themes, it was advantageous to maintain the verbatim accounts of the

participants to ensure that the voice of the AMHP came through in the research. In responding to the vignette the participants were asked to make an independent decision about what they ‘would do next’ as the AMHP in the scenario. Follow-up questions gave opportunity to participants to explain their decision in relation to risks they observed and assessed. The outcome of their decisions is outlined in Table 1.0. The contributing factors and risks relating to what AMHPs identified in their decision making are outlined later in Table 2.0.

As Table 1.0 suggests there was variance in the decisions that participants reached. Four participants made the decision that they would detain Mr Anderson under Section 2 MHA, and eleven decided that they would look for alternatives to detaining him to hospital. Although Section 3 and 4 were an option, none of the participants selected these. Six participants wanted to use powers contained within Section 135 MHA.

Where a decision is reached to detain Mr Anderson, it can be observed that AMHPs are drawing on the risks and factors which they consider to be the most pertinent to reaching that decision, one respondent commented:

I'd detain him, because of the psychosis, the weapon carrying, the threats... I would admit him on a two, because I think there is a good chance that he would, within the 28 days, consent to informal admission... But still, I want to give him that chance to engage with the services, because he has let us in. He's listened. He is angry that we have come to see him. (Social Work Participant 1)

In this example one participant felt that there was no alternative to Mr Anderson's detention, but the participant is also sensitive to the hope that mental health service might be able to engage Mr Anderson in the least restrictive way in the future. The participant here is drawing

on numerous risks such as ‘carrying a weapon’, ‘threats’ and coupled with the unpredictability of psychosis; these risks are explored later. Another example of how an AMHP weighed their decision to detain can be seen in how the AMHP considered whether to use Section 2 or 3 MHA:

I think more a Section 2. It's difficult, because he is well known, and other people might be – sorry, I'm just thinking about the CTOs. Other people might say, ‘Oh, the Section 3, because then you can consider a CTO’, but that might be a bit harsh in these circumstances, because he looks like he did engage for a while... (Nurse Participant 8)

The participant in this instance seems to be weighing their decision in the context of how others may review their decision in relation to applying for a Community Treatment Order, where a Section 3 admission would need to be in place. However, the participant considers the least restrictive option as being a Section 2 admission.

Decisions to use Section 135(1) MHA

Six participants (4 SW-AMHPS & 2 N-AMHPs) intended to seek a Section 135 warrant to access the flat again, as Mr Anderson in the vignette had asked participants to leave. Although it is not a detaining power, a Section 135 warrant does contain a holding power within a place of safety under the MHA. There was indication from the responses that this was a situation that demanded a further assessment. For these participants, ‘the decision’ was to seek a warrant, as it was the only decision they could consider at this stage. One participant explained as follows:

With his history, he has had a history of voices and stuff and he has been on antipsychotic medication in the past. I suppose yes, I would be probably obtaining a

warrant and going in to do another MHA assessment, just to make sure that everything had been explored, for his safety and the safety of others as well. (Social Work Participant 6)

In this instance, the participant does not feel that their assessment of Mr Anderson has been completed to the degree that they could reach a decision as to what to do next. The participant has interpreted from the vignette that there are potential safety issues that need to be explored further. Another participant seeking to use a warrant supported waiting to take action suggesting:

Try and get them to engage ... over the next few days. If it's clear he's not going to engage with them, then probably go around again through a MHA assessment with more resources so that you could take ... if I went back again, I'd go back with warrants and police and stuff so that he could be taken if he needed to be. (Nurse Participant 4)

Here the participant would only consider seeking a warrant, and then only when they had exhausted all other alternatives first. The participant is also discussing taking the police. It is unclear as to whether this is to execute the warrant or due to Mr Anderson's perceived risk to others.

Alternatives to admission

The majority of participants made the decision not to detain under the MHA and considered other options. The decision to offer a community alternative was considered by five participants (2 SW-AMHPS & 3 N-AMHPs), but what AMHPs considered to be a community alternative differed depending upon the locality and the resources available to

them. For some this involved home treatment, crisis teams or offering the intervention themselves. One participant suggested:

I wouldn't necessarily jump straight to assuming that he needs to be in hospital... I would think the Crisis team would have to get involved... It does not look good. Certainly I think the need for action is immediate but whether to jump straight to admission – a little bit premature. (Social Work Participant 7)

This seems to suggest that the AMHP is considering the process of engaging Mr Anderson in a graduated way, without discounting a possible need for admission in the future.

Other participants deferred making a decision (1 SW-AMHPS & 1 N-AMHPs) at the point when the question was asked. They preferred to remove the pressure from the decision-making process. One participant commented:

Yes, I would be hesitant to rush to the decision basically, and my hesitancy is driven by a number of factors. Not all of my own making as it were, there's the spirit and the code of practice in the MHA to look at the least restrictive options. I haven't formed a view, I'm forming a view, so what could be done in the way of community alternatives for a man who still retains some ability to engage? He opened the door and let us in. Overall as an answer I would take my time. I don't know how much time because that would be dependent on a number of factors. (Social Work Participant 3)

Other participants (1 SW-AMHPS & 2 N-AMHPs) decided that they would attempt to re-engage Mr Anderson. One participant considered that one of the most important factors would be to allow more time for him to reflect and also for the AMHP to reflect as well:

I would probably call him when I got back to wherever I was and see if, with the tension of us being there, us not being there anymore, if he was able to reflect on it a bit and consider a bit more deeply what was going on. I'm thinking that would be, say like in maybe an hour or two afterwards or maybe even the next day actually, to see how he feels. (Nurse Participant 1)

One participant suggested that they would attempt to re-engage him and slow the process of this re-engagement down to corresponding with him by letter, to put the onus to engage with the service on Mr Anderson:

To be honest with you, I wasn't convinced that the chap was as at a stage where he would need a [MHA] assessment as an intervention at all ... I would probably write to him and say, Look, I appreciate that you are very angry and very surprised to see us at your doorstep, but there is a genuine concern for your wellbeing. We would like to come again to talk to you. You have had a recent loss and things have been difficult for you. We would like to come and see if there is anything we can do to support you. (Nurse Participant 2)

This response draws on a non-medical perspective from a nursing AMHP who might be expected to adhere to a medical perspective. It shows an awareness of the context and the struggles Mr Anderson might be experiencing particularly in the use of 'wellbeing' and the wanting to offer support even though this may not arise from a mental health related phenomenon. The participant still wants to be involved in this referral.

Each participant evidenced through their responses that they adhered to the MHA code of practice in accordance with the 'least restrictive' options principle, even if they discounted it

in the final decision making. One participant articulated what he might have said to Mr Anderson in the process of reaching a decision.

I would want to explain to him other options that we have got, apart from going to the hospital. But then will remind him that going to hospital is an option. Then the other options about him engaging with support, people coming to see him regularly. If he allows people to come and see him, he does not have to go into hospital. But he needs help, and I will be giving him the information that I am aware of, like I just went there. Well obviously I won't be going into all those details, but I was explaining my thought process there to you. (Social Work Participant 2)

The intention of the participant here is to consider all the options that could be available to support Mr Anderson. There is a strong sense of wanting to work with him in a collaborative way.

The variation in language can also be seen below in Table 2.0 across participants. Overall eighteen AMHPs (9 SW-AMHPs & 9 N-AMHPS) highlighted features from what they read or observed about Mr Anderson's current presentation in the vignette. Noticeably two AMHPs did not discuss his presentation in their decision making and appeared to avoid focusing on this. This analysis highlighted a high level of variation and, in relation to some accounts, polarised views. Due to the variety of presentation characteristics highlighted, only particular areas are explored, as the results in Table 2.0 below are self-explanatory. The variation is interesting as it potentially highlights the nature of what AMHPs will write in their social care record or AMHP outline report, as well as linking to social constructionist perspectives due to the differing realities of interviewees. Although there is variation, the comparison between the groups does not allude to any notable differences in this regard.

Limitations

This study's findings cannot be generalised due to the small sample, but it does give an indication that differences between AMHPs based on professional background are not as dissimilar as might have previously been thought. There were limitations of using the video as the narrative had to be written around what had been already produced, including their choice of age, gender, ethnicity and background for the character. It is possible that his ethnicity was chosen by the producers, recognising the over-representation of this demographic group in compulsory detention (Francis & David et al 1989). This study was not sufficiently funded to produce new visual materials. The researcher had to consider their own reflexivity in terms of the benefits and limitations it brought to the study as he was still practicing as an AMHP. Discursively, the strength of this reflexivity rested with the researcher's familiarity and understanding about the nature of AMHP decision making. Conversely the disadvantages of this familiarity can be the researcher making assumptions about the AMHP role with an increased potential for the researcher to over identify with the situation in the vignette and the best way forward. The impact of this reflexivity also denied the opportunity to ask naïve questions to participants, due to the insider nature of this study. To reduce these disadvantages participants were not recruited from local authority areas where the researcher was known.

Discussion

Participant identification of risk and subsequent decision making between participants varied. The participants seemingly interpreting and constructing risk in differing ways due to the 'meaning' they attributed to what they observed (Rosen & Kuehlwein 1996) which was created by drawing on their values and beliefs as well as their moral and ethical viewpoints (Burr 2003; Kemshall 2002). In other words decisions were made within their socially

constructed ideological view of the world (Lock & Strong 2010). Although it can be argued that this is true of all people everywhere, very few people make decisions to limit another person's liberty in a context where the decision maker can be held to account for each decision made.

Adherence to the least restrictive principle was found in all participant responses regardless of the decision to detain or not. Four decided that detention was needed for Mr Anderson, compared with the sixteen who did not. Could these individual decisions be defended given the variation that is observed. Overall half of the sample decided to use a power under the MHA (either through detaining Mr Anderson under Section 2 or applying for a Sec 135(1) warrant to continue their assessment) the other half did not. The remaining participants focused on working with Mr Anderson using community alternatives or suspended reaching a decision. Participants did not make decisions or observations in a homogenous way according to their professional background or their AMHP status. This echoes the findings of the Peay (2003). Overall, a picture is emerging of the impact human agency on AMHP decision making and AMHPs are constructing risk by drawing on wider meanings and conventions in reaching a decision of this nature.

Experience is likely to have an impact as AMHPs inevitably draw upon their experience, practice wisdom (Sheppard 1995), knowledge and skills to achieve what they consider to be a 'sound decision' (O'Sullivan 2011). However, this will be done in the context of the perceived understandings and meanings of risk that are relative to particular societies, communities and individuals, and as such will vary accordingly (Douglas 1992). The consequence of this in terms of AMHP practice seems to be a pattern of decision making that is individual in nature of its assessment of risk and is based upon their experience and own

risk thresholds of what risk the AMHP can tolerate taking accountability for if an adverse event occurs.

This research underlines the need to better understand how AMHP decisions are reached and the contributing factors. As the vignette evidenced, even with the same circumstances differing outcomes for service users and carers can occur. Greater emphasis may need to be given to how interactions with others and with social structures (Sugiman & Gergen et al 2007) impact on the AMHPs world view. The apparent individuality of each of the 20 study participants is perhaps in some ways surprising; as cultures and conventions also arise from shared meaning (Hjelm 2014), although this may have been more evident if we had gathered data from a single geographically located AMHP team rather than across England.

Socialisation into the AMHP role via educational practices is likely also to have in impact as professional values, principles and paradigms from their education and training impact upon what is considered to be 'right' (Hjelm 2014). The anecdotal national picture of the AMHP workforce in England and Wales is similar to that found by Bogg 2011 in that the social work profession remains the dominate profession. As such it can be argued that any non-social work AMHP is likely to be assimilated into the dominant social care culture, thus challenging the widely held view that social workers have lost their unique independent role within an otherwise medically dominated service (Bailey 2012; Davidson & Campbell 2010). Social work may not have needed to have been concerned as a profession by the inclusion of non-social work professionals as AMHPs (Bailey & Liyanage 2012). The AMHP role has not been embraced extensively by non-social workers in the way government expected including by nurses who were not predicted to have been so hesitant (Rapaport 2006), given it could be seen as an autonomous step forward away from medicine (Coffey & Hannigan 2013).

Overall, this study does not support any arguments to place greater reliance of one profession's (mental health nurses or social workers) decision making over another's following a MHA assessment. In fact, this study found hardly any differences between nurse and social work AMHPs in terms of their overall approach to considering detention and as such confirms the main finding of the earlier research conducted by Bressington, Wells and Graham (2011).

Conclusions

The AMHPs in the exploratory study do not act as a homogenous professional group when reaching decisions as to whether to detain a person or not. There is evidence to suggest that AMHP decision making is subjective as AMHPs observe, interpret, and construct risk factors individually. This study has been able to offer empirical evidence from this exploratory study where previously there were largely anecdotal assertions. The main variations between the 20 participants were essentially individualistic, and bore little connectivity to professional backgrounds per se.

The findings of this study have challenged several stereotypes and assumptions which have existed pre and post the MHA 2007 in the literature. In this study nurse AMHPs were not preoccupied with medication in their risk assessments while social workers seemed more focused on medication than anticipated by the author. Also, social workers did not highlight social factors to a greater degree than nurses in their assessments. All participants demonstrated their adherence to the principle of least restrictive practice as looking for proportionate alternatives to detention.

This study has highlighted that outcomes for service users can be expected to vary due to the variance in worldviews and perceptions of risk that are contained within individual AMHP

practice. This variance would seem to emphasise the need for AMHPs to have the ability to clearly articulate the decision-making process which led to a decision being reached rather than seeking uniformity in decision-making.

The need to continually review AMHP decision making from referral discussion to detention decision seems continually necessary, as the majority of AMHP practice occurs away from public scrutiny (Sheppard 1993) where independent evaluation is not possible. A balance needs to be struck between protecting a person's dignity and confidentiality and ensuring AMHP practice is sufficiently scrutinised and transparent. There is clear evidence that AMHPs need to be reflective practitioners firstly to understand their own risk thresholds and secondly to consider the factors that have a disproportionate influence on their decision making. There is a role therefore for reflective supervision and policies and procedures to support these arrangements being in operation across health and social care settings where AMHPs work.

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Table 1.0 What participants decided to do following the vignette		
	Nurse AMHPs	Social Work AMHPs
Section 4 MHA (<i>emergency detention for 72 hours</i>)	0	0
Section 2 MHA (<i>to detain for up to 28 days</i>)	2	2
Section 3 MHA (<i>to detain up to 6 months</i>)	0	0
Community Treatment (NOT CTO) (<i>supported in their own home by a specialist team</i>)	3	2
Try to re-engage (Mental health team to visit, or telephone again without using the MHA)	2	1
Seek a Sec 135(1) warrant (<i>Return to the house with assistance of the police to gain entry and hold the occupant</i>)	2	4
Postpone making a decision (Participant could not make a decision)	1	1

Table 2.0 – Participants’ observations of Mr Anderson’s current presentation		
Presentation of Mr Anderson	Social Work AMHPs	Nurse AMHPs
Angry	4	2
Chaotic	1	0
Depressed	1	1
Guarded or suspicious	3	3
Mental disorder	1	1
NO self-neglect	2	3
NOT psychotic	2	1
Paranoid	3	4
Psychotic	1	2
Risk to self	1	2
Risk to others	2	1
Risk to self	1	2
Self-neglect	2	0
Sleep deprived	1	0
Suicidal ideation	3	1

Weight loss	1	0
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