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Using the law in social work Approved Mental Health Professional practice

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Thesis submitted for the Doctorate in Social Work

University of Sussex

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Learning more about the relationship between law and social work AMHP practice would not have been possible without the support of several people, who I would like to thank here.

I am grateful to the social work Approved Mental Health Professionals who participated in the research. Without them the study would not have been possible. I was moved by their stories of using the law in practice and struck by their wisdom and integrity.

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Thesis Summary

UNIVERSITY OF SUSSEX

SIMON NICHOLAS ABBOTT

SUBMITTED FOR THE DOCTORATE IN SOCIAL WORK

USING THE LAW IN SOCIAL WORK APPROVED MENTAL HEALTH
PROFESSIONAL PRACTICE

SUMMARY

The research study focuses on how social work Approved Mental Health Professionals (AMHPs) use the law in practice. AMHPs in England and Wales have statutory powers under the Mental Health Act 1983 (MHA) to detain people in hospital for assessment and/or treatment. The stakes in this area of law and social work are high: practitioners deal with important issues concerning individual liberty that have profound implications in relation to the power of the state to intervene in the lives of citizens, where notions of autonomy, protection, coercion and care sit in tension.

The study explores the relationship between law and social work practice by interpreting meanings contained in case stories told by social work AMHPs about recent Mental Health Act assessments that they undertook. Eleven social work AMHPs, purposively selected from three different local authorities in England, participated in the study, which used qualitative in-depth interviews to collect data about using the law in circumstances where compulsory admission to hospital was a possibility. The use of case stories encouraged participants to provide a rich description of events as they unfolded over time. The data were analysed using Framework analysis (Ritchie and Spencer 1994). Computer Assisted Qualitative Data Analysis in the form of NVIVO was utilized to manage the data, and to support data analysis.

Five themes are presented in the findings chapter: understanding the referral situation; understanding the individual; understanding the situation causing concern; community versus containment, and relationships and resources.

The study contributes to knowledge by illuminating how the use of law in practice is an inherently socio-relational undertaking, involving embodied practice. Bourdieu's (1977) concept of habitus is used to make sense of participants' accounts of the action that unfolds when they use the law. A further contribution is made to knowledge on legal literacy in social work, where there is little empirical research focusing on how social workers use the law, and still less on how mental health social workers use the law to consider compulsory powers under mental health legislation. The organisational factors impacting on how participants relate to the law are outlined and discussed drawing on legal consciousness theory (Ewick and Sibley 1998; Sibley 2005), together with an account of how participants adapt to this, drawing on street level bureaucracy (Lipsky 1990).

The thesis explores the distinction in practice between medical and social perspectives occupied by AMHPs when they use the law in circumstances where compulsory admission to psychiatric hospital is a possibility. The study findings suggest that AMHPs' perspectives are holistic and social and can be understood as occupying a socio-medical-juridical perspective. The most important factor in the decision to use compulsory powers in mental health law to detain a person involves the AMHP taking a wide perspective in terms of their understanding of the individual that is relational to the understanding of others, and understanding the person in their environment in relation to how they relate to others. The thesis outlines that 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. This leads to the further argument that notwithstanding a holistic and social perspective, this does not necessarily lead to less coercive interventions. Medical and social perspectives thus often lead to the same conclusions in relation to decisions to use the law to detain.

Table of contents

Table of Contents

Using the law in social work Approved Mental Health Professional practice.....	1
Acknowledgements	2
Thesis Summary	4
Table of contents.....	6
List of tables and abbreviations	9
Chapter 1: Introduction	11
1. Introduction	11
2. Context.....	12
3. Background information	15
3.1 Definitions	15
3.2 The significance of the social perspective.....	17
4. Research focus and approach	18
5. Justification.....	20
6. Structure of thesis	21
Chapter 2: Literature Review	24
1. Introduction	24
2. Literature review approach and method	24
Table 1 - Literature review approach and method	25
3. Social contexts	28
4. Occupying the social perspective.....	32
5. Tensions applying mental health law in practice.	36
6. Summary of key findings	44
Chapter 3: Theoretical Framework	46
1. Introduction	46
2. Theoretical Framework	46
3. Legal Consciousness.....	48
4. Street level bureaucracy	49
5. Bourdieu's theory of practice	52
5.1 Habitus.....	53
5.2 Capital.....	54
5.3 Field	55
5.4 The force of law	56
6. Integrating Bourdieu with AMHP use of law	60
7. Integrating theoretical perspectives into a framework	61
8. Conclusion	63
Chapter 4: Methodology.....	66
1. Introduction	66
2. Practitioner/researcher identity.....	66

2.1 Reflexivity	66
2.2 Influence of my practice on the research	67
2.3 Influence of the research on my practice	69
2.4 Insider/outsider identity	70
2.5 Researcher and respondent power dynamics and ethics	72
3. Ontology and Epistemology	73
4. Choosing approaches to gathering data	75
5. Research strategy	76
5.1 Research setting and Participants	76
6. Gaining access	79
7. Data collection methods	81
7.1 Research Instruments	81
7.2 Accounting for the difference between what people do and what people say that they do	84
7.3 Practitioner Diaries	85
8. Data analysis	86
9. Ethical considerations	90
10. Conclusion	92
Chapter 5: Findings.....	94
1. Introduction	94
Table 3-Themes.....	95
2. Theme 1: Understanding the referral situation	95
Table 4 – The nature of risks confronting AMHPs.....	102
3. Theme 2: Understanding the individual.....	109
4. Theme 3: Understanding the situation causing concern.....	119
4.1 Family members' or carers' perspectives on what needs to be done	120
4.2 Risk to family and others	121
4.3 Risk to health and safety	122
5. Theme 4: Community versus Containment.....	123
5.1 Feasibility of being in the community.....	123
5.2 Hospital as a place to enable plans to be put in place for the future.....	124
5.3 Trust.....	126
5.4 Medication in the community	128
5.5 Ability of family to cope	130
5.6 Feasibility - Community support options	132
6. Theme 5: Relationships and resources	134
6.1 Autonomy as an AMHP	134
6.2 Inter-professional working relationships	135
6.3 Inter-agency working relationships	136
7. Conclusion	138
Chapter 6: Discussion	139
1. Introduction	139
2. Embodying the law in social work AMHP practice	140
3. Social work AMHP practice and legal literacy	150
4. A socio-medical-juridical perspective	159
5. Conclusion	168
Chapter 7: Conclusion.....	171

1.Introduction	171
2. The study purpose and rationale	171
2.2 Review of study design	173
2.3 Review of key findings	174
2.4 Limitations of the study	177
3. Looking forward: implications of the research study for AMHP practice and research.....	180
3.1 Reconciling tensions between autonomy and coercion.....	180
3.2 Orienting habits and dispositions toward action based on human rights	181
3.3 Future Research	185
3.4 Action oriented to human rights in teaching and learning.....	186
3.5 Communication and acute mental distress	187
4.Dissemination of research	188
References	189
Appendices	198
Appendix 1 - Participants information sheet.....	198
Appendix 2 - Participants consent form.....	203
Appendix 3 -Topic list for interviews.....	204
Appendix 4 - Practitioner diary template	204
Appendix 5-Ethics approval certificate	207
Appendix 6-AMHP case story	210
Appendix 7-A case story: using the law in practice	219
Appendix 8- Framework Analysis Chart 3- Understanding the individual.	228

List of tables and abbreviations

Table	Title	Page
1	Literature review approach and method	26
2	Research participants	80
3	Themes	96
4	The nature of risks confronting AMHPs	103

List of abbreviations

AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
MHA	Mental Health Act 1983 (as amended)
MHA assessment	Mental Health Act assessment
CPA	Care Programme Approach

Chapter 1: Introduction

1. Introduction

Mental health social workers in the UK occupy a central role in the legal process of compulsory admission to a psychiatric hospital (Campbell 2010; Davidson, Brophy and Campbell 2016). In England and Wales social work is by implication the lead profession for Approved Mental Health Professionals (Davidson, Brophy and Campbell 2016). The role of an Approved Mental Health Professional (hereafter AMHP) is to bring a social perspective to bear on whether someone ought to be detained, based on two medical recommendations, taking into consideration all the relevant circumstances of the case including less restrictive alternatives. The role involves complex decision-making processes, which balance caring and controlling functions (Campbell et al 2006).

It has been suggested (Manteklow et al 2002) that the role of the mental health social worker in compulsory admission represents an indispensable component of quality mental health services as an independent voice outside of the medical hegemony (Manteklow et al 2002). It has also been argued that their role is compromised by organisational and resource demands that often reduce the space for proactive, empowering engagement with service users and their carers (Campbell 2010). The inherent tensions manifest in a struggle for social work to maintain a commitment to emancipatory and recovery oriented approaches in the context of resource constraints limiting effective community support options for people experiencing acute mental distress (Campbell and Davidson 2009). In England and Wales these dynamic and often shifting tensions occur in the context of a legal mandate provided by the Mental Health Act 1983 (as amended 2007) (hereafter MHA); therefore, understanding how AMHPs use the law in practice represents a crucial focus. This acknowledges that a legal mandate is not a substitute for an approach that articulates the complex relationship between law and social work practice (Braye & Preston-

Shoot 2006) to disentangle the inherent tensions outlined above.

This doctoral study focuses on how social work Approved Mental Health Professionals (AMHPs) use the law in practice. AMHPs in England and Wales have statutory powers under the Mental Health Act 1983 (hereafter MHA) to detain people in hospital for assessment and/or treatment. It explores the relationship between law and social work practice by interpreting meanings contained in case stories told by social work AMHPs about recent MHA assessments that they undertook. Eleven social work AMHPs, purposively selected from three different local authorities in England, participated in the study, which used qualitative in-depth interviews to collect data about using the law in circumstances where compulsory admission to hospital was a possibility. The use of case stories encouraged participants to provide a rich description of events as they unfolded over time. The data were analysed using framework analysis (Ritchie and Spencer 1994). Computer Assisted Qualitative Data Analysis in the form of NVIVO was utilized to manage the data, and to support data analysis.

This chapter introduces the thesis, providing a statement of the topic and problem under investigation. It does this by providing background information and a statement of the problem or 'gap' that is addressed. An outline of the aims of the study, together with a brief description of the research setting and methods, are also provided before the chapter concludes with an outline of the structure of the thesis.

2. Context

The Mental Health Act 1983 (as amended 2007) imposes autonomous decision-making responsibility on an AMHP, who is usually a social worker, to decide whether to detain a person in a psychiatric hospital for assessment or treatment. The law envisages that the AMHP brings a social perspective to bear on the assessment and consideration of least restrictive options. The stakes in this area of law and social work are high as they deal with important issues concerning individual liberty that have profound implications in relation to the power of the state to intervene in the lives of citizens, where notions of

compulsion, coercion, care and autonomy are often in tension. The expectations provided by s139(1) MHA in relation to these decisions stipulate that any act purporting to be carried under the MHA is done in good faith and with reasonable care, otherwise liability arises to civil or criminal proceedings for the professionals involved.

There has been much interest recently in the numbers of people so detained, which have reached a 10-year high (NHS Digital 2016). In 2015/16, there was a total of 63,622 detentions, an increase of 5,223 (9%) compared to 2014/15 (58,399) and a rise of 10% between 2013/14 (53,176) and 2014/15. A decade previously the number of people detained during 2005/06 was 43,361. AMHPs are involved in the increase in detentions as they make the ultimate decision as to whether someone should be detained or not. How they use the law to make such decisions therefore resonates as an important area worthy of research.

Internationally there has been an emphasis on the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2011) leading to calls for the repeal of laws that lead to someone to be deprived of their liberty because of a disability. This has had a significant impact on debates about mental health and mental capacity law reform (McSherry and Freckelton 2015) with an increasing emphasis and concern for human rights discussed in the literature for responding to the needs of people with disabilities (Spandler and Calton 2009) resonating with mental health social work in particular (Campbell et al 2006; Davidson and Campbell 2007; Campbell and Davidson 2009; Brophy and McDermott 2013; Szmukler 2008; Maylea 2017; Courtney and Moulding 2014; Davidson, Brophy and Campbell 2016).

The relationship between coercion and care is complex (McSherry and Freckelton 2015; Davidson and Campbell 2007; Campbell and Davidson 2009). This is reflected in debates where coercive care is on the one hand presented as a 'common sense' response compatible with the well-being of individuals and the safety of the community' (Weller in McSherry and Freckelton 2015:29) or on the other hand as an affront to human rights and the general principles of the CRPD (Maylea 2017) compromising inherent dignity, individual autonomy

and independence (Article 3 CRPD). A counter argument to the CRPD suggests that it contains provisions that threaten to disrupt 'long-standing approaches to mental health law, including efforts to protect people with severe cognitive and emotional impairments, and leave many people with disabilities worse off than before' (Applebaum 2016: 1).

For Weller (in McSherry and Freckelton, 2015: 16) an inquiry into coercion in psychiatry 'invites interrogation' of forms of coercive care; a list of pertinent questions highlighted by Weller includes 'who is authorised to make such decisions?' In England and Wales the person authorised to make that decision is an AMHP. This reinforces the importance of a study that focusses on how AMHPs use the law to decide whether someone should be detained in hospital.

This area of social work practice has also raised questions about whether it is ever ethical to detain someone under the MHA (Kinney 2009), that mental health social work needs to reject involuntary treatment out of hand (Maylea 2017) and position itself alongside libertarian approaches to mental health, law and liberty (Szasz 1971). It has also been argued that resort to coercion involving detention in hospital represents a failure of care by mental health services (Weller in McSherry and Freckelton 2015). There are of course all sorts of rights to be considered; the right to be assessed and treated for mental disorder at a time of acute mental distress and the rights of family and loved ones close to the person affected are among the rights confronted by the AMHP and do not necessarily have to be incompatible with the codified rights of the CRPD (2011).

It has been argued that there is a need for 'more nuanced and less dichotomous interpretations of the moral imperatives for autonomy and protection' (Braye, Orr, and Preston-Shoot 2017: 9). In the context of the coercive component in mental health social work this acknowledges opportunities for developing practice skills and models that add greater sophistication to the role, emphasising a situated and holistic approach rather than one of attempting to coerce and control the person in the absence of acknowledging the coercive nature of the role (Campbell et al 2006; Brophy and McDermott 2013; Campbell and Davidson 2009; Davidson and Campbell

2007). Emerging literature suggests that there are spaces for creative approaches to involuntary treatment that are consistent with social work values and ethics and with aspects of a recovery orientation (Courtney and Moulding 2014). The complex interplay of tensions between autonomy and liberty on the one hand and coercion and detention in hospital on the other makes this study an interesting and important area of research.

3. Background information

3.1 Definitions

Approved Mental Health Professional (AMHP)

An AMHP has a statutory role under the provisions of the MHA. The AMHP has key duties and powers under the MHA that include making the final decision whether someone should be detained or not, based on medical recommendations. Prior to November 2008 the role carried out by the AMHP was referred to as an 'Approved Social Worker' (ASW). The 2007 amendments to the Mental Health Act 1983 changed the terminology. The literature therefore refers to this role as either an ASW or an AMHP, depending on whether it was written prior to or following the 2007 amendments. The main change reflected in the change of name related to the wider body of professionals who could now perform the AMHP role: social workers, clinical psychologists, occupational therapists and psychiatric nurses. However, the widening of professional backgrounds has had a very modest impact in practice. Social work remains the core profession for AMHPs (Allen 2014) and local authorities remain the body responsible for appointing and approving AMHPs. In Northern Ireland the ASW role remains unchanged. In Scotland, social workers perform a similar role as Mental Health Officers. In England and Wales mental health social workers are eligible to qualify as AMHPs after two years of post-qualifying practice. The training lasts approximately 6 months combining classroom teaching with a practice placement. It offers a broad curriculum comprising models of mental disorder with an emphasis on social perspectives. In-depth knowledge of mental health law and related legislation is a key expectation and in-depth knowledge of the law by ASWs/AMHPs in comparison

to psychiatrists has been highlighted in the mental health law literature (Peay 2003; Campbell et al 2001; Manteklow et al 2002).

Mental Health Act (MHA) assessment

A Mental Health Act assessment (MHA assessment) determines whether someone needs to be admitted to hospital for assessment and treatment and, if so, whether they should be admitted voluntarily or compelled by detention under the provisions of the MHA. A MHA assessment can take place anywhere: in a hospital, on the street, in a police station, in a person's home. There is a requirement that the person is assessed in a suitable manner so must be physically present with the assessors at the time of the MHA assessment. For example, the person could not be interviewed under the MHA through their letterbox. There is no lower or upper age limit. A MHA assessment is guided by Part 2 of the MHA and the relevant provisions are sometimes referred to as 'civil sections', in contrast to Part 3 MHA that deals with admissions to hospital as part of the disposal of a case in criminal proceedings. Admission under Section 2 is for the purposes of assessment or assessment followed by treatment in hospital. The duration for section 2 MHA is up to 28 days; it cannot be renewed at the end of the 28-day period. The grounds are that

'he is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

he/she ought to be so detained in the interests of his own health or safety or with a view to the protection of others'.

Admission under Section 3 MHA is for the purposes of treatment in a hospital. The duration of section 3 MHA is up to 6 months and can be renewed at the end of the first 6-month period, and yearly thereafter. The grounds are that

'he is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

'it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and

appropriate medical treatment is available for him'.

The MHA assessment involves inter-disciplinary decision-making. Both forms of application by the AMHP must be based on two valid medical recommendations, made by different, appropriately qualified medical practitioners (doctors). Normally, at least one of these doctors must be approved under section 12 MHA. The AMHP cannot consider making an application unless they receive the required medical recommendations for either section 2 or section 3. (The MHA does provide for emergency applications that only involve one doctor and an AMHP, however these are not as common as section 2 and section 3 and do not form the basis of MHA assessments discussed by participants in this study.) The AMHP must undertake the MHA assessment with at least one of the doctors, preferably both, although it is common for one doctor to make a medical recommendation and then trigger an assessment, with the AMHP arranging the second doctor. Whilst the MHA assessment does not involve the AMHP in isolation from the other professionals, the role of the AMHP is in focus as they make the final autonomous decision on whether the person is detained.

3.2 The significance of the social perspective

The law envisages different 'perspectives' for the AMHP and the doctors involved in undertaking a MHA assessment. A brief explanation of this is provided here, as context for the later focus on the significance of 'perspective' in both the literature and in my findings.

The role of an AMHP is to provide an independent view about whether someone assessed under the MHA should be detained or not, taking into account the 'social and medical evidence' (DH 2015) about whether there are alternatives to detention under the MHA. Additionally, they are required to bring a social perspective to bear on their decision, taking account of the least

restrictive option. There are two key points to make here. The first is that the social perspective is framed as an event, or a 'now moment'. In the Code of Practice (DH2015) it is stated that the social perspective required of the AMHP is located at the 'now' point of the decision whether to detain. Secondly, social and medical are framed in an opposing relationship as if they are somehow able to be neatly separated (i.e. 'social *and* medical evidence'). The perception of the medical and social as separated is further complicated by the fact that the AMHP is asked to take into consideration, in addition to the 'social evidence', 'medical evidence' using a social perspective thereby further emphasising that the lines between the medical and the social can be easily separated.

4. Research focus and approach

The current study focuses on the views of AMHPs in describing how they use the law in practice. The aim of study is to understand how social work AMHPs use the law in practice where compulsory admission to hospital is a consideration. The rationale for using a qualitative methodology arose from the type of questions that the research sought to explore. Denzin and Lincoln (2011) explain that qualitative research seeks answers to questions that emphasise how social experience is created and given meaning.

The use of case stories provides a rich form of data, which aimed to elicit the taken for granted aspects of using the law in practice and enabled me to get a glimpse of how the participants made sense of using the law.

The research question is formulated as:

- 1) How do social work AMHPs use the law in the context of assessment for admission to hospital under the MHA?

Sub questions for consideration are:

- a) How does the concept of legal literacy translate into social work AMHP practice?

- b) How do AMHPs employ a social perspective when using the law in practice?
- c) What are the priorities and challenges they face?

Data were collected using in-depth semi structured interviews and practitioner diaries. The purpose of the interviews was to elicit AMHPs' experiences of carrying out MHA assessments that they had recently undertaken. The use of case stories encouraged participants to provide a rich description of events as they un-folded over time during the actual MHA assessment - an assessment process that usually spanned several hours, and sometimes days. Practitioner diaries were an attempt to capture the contemporaneous experience of undertaking a MHA assessment by asking participants to make diary entries following an assessment, outlining their feelings and impressions.

The study can be characterised as working *with* stories told by AMHPs about a recent MHA assessment as opposed to working *on* them, using the potential of stories to illuminate how social workers use law in this area of practice, as opposed to focusing on the form or structure of the narratives of participants (Labov 1973). Story-based socio-legal research that has collected stories in fieldwork demonstrates the potential for how they can reveal actors' tacit knowledge and norms (Sarat 1990; Erickson and Shearing 1991; Musheno and Maynard-Moody (2003).

The research paradigm that best encapsulates the theoretical framework surrounding my research is the branch of phenomenology referred to as hermeneutic phenomenology. According to van Manen (1990:180) 'hermeneutic phenomenology tries to be attentive to both terms of its methodology, it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as un-interpreted phenomena'. The connection between a hermeneutic phenomenological research paradigm and the case stories method in my research is captured by Langridge (2007) who proposes that the hermeneutic turn of phenomenology is based on the view that our

experience can best be understood through stories we tell of that experience. Therefore, I argue that to understand how law is used in practice we need to explore the stories told by people about their experience.

5. Justification

The problem that the study addresses is the gap in knowledge and understanding about the process of using the law in practice in the undertaking of a MHA assessment from the perspective of the AMHP. Exploring this issue provides an opportunity to explain this (Campbell et al 2006). Drawing on the social work law literature (Braye and Preston Shoot 1990; 2006; Braye, Preston-Shoot, and Wigley 2011; Preston-Shoot and McKimm 2012) provides an opportunity to explore how mental health social workers can resolve the tension between the requirement to coerce, legally, whilst also striving to protect human rights (Campbell 2010). The study further addresses the proposal by Campbell (2010) that in critically understanding how they are positioned across complex legal, organisational and human systems, mental health social workers may be better prepared to work with the ambiguities of the role. The study also addresses the previous appeals for an exploration of how legal literacy translates into practice (Braye, Preston-Shoot and Wigley 2011; Preston-Shoot and McKimm 2012), and in doing so to articulate the complexity of the task of using the law in social work AMHP practice (Braye and Preston-Shoot 1990).

Unlike earlier studies that focused on factors that influence decision-making (Quirk et al 2000, Buckland 2016, Fistein et al 2016), the focus of this study is on how social work AMHPs use the law in practice when undertaking MHA assessments; the relationship between law and practice is therefore a central focus. The question of how social workers use the law has been the subject of interest in the literature from the early 1990s, Braye and Preston Shoot (1990) laying the foundation for a more nuanced response to what risked becoming a polarised debate about whether law or ethics lay at the heart of social work. In highlighting the danger of over-simplifying a relationship of considerable complexity, Braye and Preston-Shoot (p334) called for 'a far more searching analysis of the interplay between them'. Subsequent literature has addressed

tensions in the relationship between mental health social work and mental health law (Campbell et al 2006; Davidson and Campbell 2007; Campbell and Davidson 2009; Brophy and McDermott 2013; Maylea 2017; Courtney and Moulding 2014; Davidson, Brophy and Campbell 2016), how law is taught and assessed in social work education (Braye & Preston-Shoot 2005; Braye, Preston-Shoot, & Thorpe, 2007), social work students' law learning and confidence in using the law (Preston-Shoot and McGill 2012), critical analysis of legal rules (Braye & Preston-Shoot 2010), and how the law is used in practice decisions in children and families and adult services, providing empirical evidence of the nuanced and complex nature of law and social work practice (Braye, Preston-Shoot, and Wigley 2011). The concept of legal literacy (Braye and Preston-Shoot 2006b, Braye, Preston-Shoot, and Wigley 2011, Preston-Shoot and McGill 2012) has provided a useful conceptualisation of the law/social work relationship whereby three imperatives are highlighted: doing things right, referring to the need for knowledgeable use of legal rules; doing right things, referring to law's interface with values; and rights thinking, referring to action by reference to human rights (Braye and Preston-Shoot 2006b; Preston-Shoot and McKimm 2012). The current study therefore seeks to build on this literature by answering the need for further research in this field. The study also addresses a lack of empirical studies on the relationship between law and social work. Unlike earlier research that explores how decisions are made under the MHA that use case vignettes (Morgan 1999; Peay 2003; O'Hare et al 2013), this study uses accounts of situations that have occurred in real practice. The focus is to explore how the AMHP moves forward across the terrain of practice, interacting with other people including professionals and family members, thereby capturing the use of law as a social process as opposed to an event or 'now moment'.

6. Structure of thesis

In this chapter I have outlined the context of the research and provided background information including clarification of definitions. I have also introduced the topic and specific problem under investigation together with a justification for the thesis.

The remaining chapters are outlined as follows. Chapter 2 contextualises the study with a review of literature on the topic of how AMHPs use the law in practice. The chapter outlines the literature search strategy and presents an analysis of the literature review under three overarching themes; 'social contexts', 'occupying the social perspective', and 'tensions applying mental health law in practice'. The chapter concludes with a summary of the key findings of the review with gaps in knowledge stated and evidenced.

Chapter 3 outlines the theoretical framework underpinning the study, which is used to make sense of the empirical data. This framework is formed by combining theoretical lenses drawn from legal consciousness (Ewick and Sibley 1998; Sibley 2005), street level bureaucracy (Lipsky 1980) and practice theory Bourdieu (1977). Further, Bourdieu's notion of the juridical field (1987) is drawn on to argue that this is the field of play in the context of social work AMHPs using the law in practice.

Chapter 4 is an account of the research methodology and methods. This is presented as a narrative highlighting the iterative experience of the study where the methodology and my identity as a researcher are implicated and inextricably linked to the research study.

Chapter 5 provides the findings, organised thematically under five themes: 'understanding the referral situation'; 'understanding the individual; understanding the situation causing concern; 'community versus containment'; 'relationships and resources'.

Chapter 6 provides a discussion of the findings in three parts. In the first I draw on practice theory (Bourdieu 1977), legal consciousness (Ewick and Sibley 1998; Sibley 2005), and street level bureaucracy (Lipsky 1980) to illuminate my findings, arguing that using the law in social work AMHP practice involves an embodied practice. In the second I discuss how the concept of legal literacy translates into practice when social work AMHPS use the law. And finally, I argue that social worker AMHPs perspectives can be described as socio-medical-juridical: that AMHPs enact the law in practice using a wide social

perspective that provides depth to a medical perspective where the social and medical are not necessarily in tension with each other, leading to my proposition that different perspectives don't always equate with different decisions. This also includes perspectives on process not just perspectives on pathology or other characteristics of the person assessed.

Chapter 7 provides a review of the thesis by looking back on the steps of the argument, emphasising the key messages. It also provides an interpretation that points forwards to the future in terms of implications and recommendations. The chapter provides a concise review of the study purpose and findings, methods, relationships with previous research, limitations, challenges, implications for research and practice, dissemination plans, and contribution of the study to research.

Appendix 1 contains the participant information sheet provided to research participants. Appendix 2 contains the consent form for research participants. Appendix 3 contains the topic list used when interviewing participants. Appendix 4 contains the participant diary template. Appendix 5 contains the ethics approval certificate. Appendix 6 contains the verbatim transcript of one of the interviews. Appendix 7 provides a precis of an entire case story from start to finish to demonstrate how a whole story illustrates the themes that emerged from the cross-sectional analysis of the data. Appendix 8 contains a framework analysis chart. The chart follows the framework method. This involved ordering the data so that material with similar properties was located together to develop a thematic structure. Each main category and associated sub classifications are plotted on a separate thematic chart. Within each individual chart each participant in the research was allocated a row in the matrix while each sub topic was displayed in a separate column. Each column was assigned a separate number to enable easy referencing between columns.

Chapter 2: Literature Review

1. Introduction

This chapter presents a literature review on the topic of how AMHPs use the law in practice; it provides a critical discussion of the literature and raises implications related to the study. The chapter outlines the literature search strategy and analyses the literature under three overarching themes: 'social contexts', 'occupying the social perspective', and 'tensions applying mental health law in practice'. The chapter concludes with a summary of the key findings of the review with gaps in knowledge stated.

2. Literature review approach and method

Literature was searched using the electronic databases Applied Social Science Index Abstract (ASSIA), SCOPUS, and Social Care Online (SCIE). The search terms used were 'Approved Mental Health Professional AND Mental Health Act', 'Approved Social Worker AND Mental Health Act', 'Mental Health Act AND decision-making', 'Approved Mental Health Professional AND mental health law' and 'Approved Social Worker AND mental health law'. The final search term yielded a further three papers on SCIE. Reference chaining was also used to source further literature. Duplicates yielded at the search stage were eliminated; the table indicating papers sourced includes the duplicate papers.

Table 1 - Literature review approach and method

Data base	Key words searched	Papers sourced	Number meeting inclusion criteria
Applied Social Sciences Index (ASSIA)	<p>Approved Mental Health Professional AND Mental Health Act</p> <p>Approved Social Worker AND Mental Health Act</p> <p>Mental Health Act AND decision-making</p>	<p>42</p> <p>16</p> <p>99</p>	21
SCOPUS	<p>Approved Mental Health Professional AND Mental Health Act</p> <p>Approved Social Worker AND Mental Health Act</p> <p>Mental Health Act AND decision-making</p>	<p>24</p> <p>34</p> <p>69</p>	24
Social Care Online	Approved Mental Health	14	3

	Professional AND Mental Health Act Approved Social Worker AND Mental Health Act Mental Health Act AND decision- making	35	
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The scope of the literature under review is limited to research studies and conceptual literature from the United Kingdom. The reason for this is that UK social work occupies a unique role in relation to its involvement in compulsory powers under mental health legislation (Huxley and Webber 2004, Campbell 2010). The reason for including conceptual literature, which does not report empirical research, is that this provides context and illuminates debate on key issues in relation to the questions asked of the literature. The scope is restricted to papers published in English between 1983 and the end of May 2017. The language restriction is a pragmatic choice whilst the date restriction corresponds with contemporary mental health legislation. The papers included were purposively selected according to whether they were clearly concerned with how social work ASWs or AMHPs used the MHA. All abstracts were screened, and full texts of the literature that appeared to meet the inclusion criteria were sourced and read. The literature was further refined for relevance by excluding literature that on full reading was deemed not relevant. A data extraction tool was used for each paper considered relevant for inclusion in the review, extracting the following data from the literature: characteristics of research participants, aims of the study, methods of data collection and data analysis, findings, key concepts, areas of debate/controversy, and strengths and weaknesses of the research. In line with Dixon-Woods et al (2006), inclusion privileged papers that appeared to be relevant, rather than study types or adherence to specific methodological criteria.

The decision to apply this approach to the literature review was based on an evaluation that it worked for the type of questions asked of the literature, which focus on experiences. The approach was used as it offered a systematic way of approaching the literature review without following the rigid criteria and hierarchy of evidence required of Cochrane and Campbell style systematic review methods that would, in a social work context, have excluded most relevant studies yielded (Sharland 2012).

Following Dixon-Woods et al (2006), the quality of papers reporting research studies was appraised using the following considerations as a guiding principle:

1. Are the aims and objectives of the research clearly stated?
2. Is the research design clearly specified and appropriate for the aims and objectives of the research?
3. Do the researchers provide a clear account of the process by which their findings were reproduced?
4. Do the researchers display enough data to support their interpretations and conclusions?
5. Is the method of analysis appropriate and adequately explicated?

No papers were excluded based on lacking adherence to the guiding principles outlined.

The literature review began with detailed and multiple reading of the papers, gradually identifying recurring issues and noting these down. These were then grouped into emerging themes which aimed to capture the phenomena through an inductive approach.

The results of the literature review are now presented under the themes of social contexts, occupying the social perspective and tensions applying mental health law in practice.

3. Social contexts

The papers contributing to this theme deal with both the nature of AMHP work and the social factors involved with it, because the significance of social contexts is an over-arching theme that cuts across both aspects highlighted in the literature.

Emotional labour

The literature sheds light on the experiences of the emotional labour involved in AMHP work. The term 'emotional labour' refers to the process by which workers are expected to manage their feelings in accordance with organizationally defined rules and guidelines (Wharton 2009).

The concept of emotional labour has been elucidated, in the social work context, by Green (2017), who draws on Hochschild (1983) to explain that emotional labour comprises 'surface acting' where emotions are falsely expressed and 'depth acting' where employees genuinely feel the emotions professionally enacted. The current discussion of emotional labour focuses on the latter: the genuine expression of emotions enacted when performing the AMHP role (Gray 2009).

This encompasses findings that this work is stressful and can lead to burnout and stress (Evans et al 2006; Gregor 2010), contrasted with findings that suggest the potential for both 'dirty work' and 'prestigious work' identities (Morris, 2016; Walton, 2016). Morris (2016) draws on the concept of 'dirty work' proposed by Hughes (1971), who defines this as a stock of activities, which society may consider physically disgusting, a symbol of degradation, or an aspect that offends a person's dignity. This often leads people doing this work to need to find ways to bolster the self-image that comes from engaging in these activities in the face of the repulsion they inspire in others.

Evans et al (2006) carried out a study to examine the prevalence of stress, burnout and job satisfaction among mental health social workers, including ASWs, and the factors responsible for this. A postal survey incorporating the General Health Questionnaire, Maslach Burnout Inventory, Karasek job content questionnaire and a job satisfaction measure was sent to 610 mental health social workers in England and Wales. The 237 respondents reported high levels of stress and emotional exhaustion and low levels of satisfaction; 111 (47%) showed significant symptomatology and distress, which is at twice the level reported by similar surveys of psychiatrists. Feeling undervalued at work, excessive job demands, limited latitude in decision-making, and unhappiness about the place of mental health social workers in modern services contributed to the poor job satisfaction and most aspects of burnout. Those who had Approved Social Worker status had greater dissatisfaction. The study does not include details of the factors that attributed greater dissatisfaction to social workers with approved status.

In contrast Morris (2016) undertook a study that reported more nuanced findings about the impact of AMHP work and the emotional labour of using the law in practice, exploring the notion of 'dirty work' (Hughes, 1971) in relation to the then newly created role of the AMHP. The study focused on whether the decision by an AMHP to make an application for compulsory detention to psychiatric hospital was considered 'dirty work' by AMHP participants. Seventeen social work AMHPs across England were interviewed employing the method of narrative interviews that were then analysed using dialogical narrative analysis. The findings provide a convincing picture that presents AMHP work as prestigious and representing an advanced form of social work, although it should also be noted that the social workers also acknowledged aspects of AMHP work that they considered as 'dirty work'; these aspects included a lack of psychiatric beds to admit people to, the complex co-ordination procedures and the overall emotional labour of the work. The findings reported by Morris (2016) are further supported by Watson (2016) who carried out semi-structured interviews with AMHP trainees across Southern England to find out about the motivation of participants to qualify as AMHPs. The findings reported suggest that social work participants value the MHA

assessment as a contained piece of work that incorporates a high degree of professional discretion.

Social Factors

The impact of social factors on compulsory admission to psychiatric hospital is strongly established in the literature (Hatfield et al 1997; Hatfield 2008; Barnes, Bowl and Fisher, 1990; Manteklow et al 2002; Campbell et al 2001). Hatfield et al (1997) provide a convincing rationale for the inclusion of social assessment in psychiatric emergencies, which is further linked to a literature that confirms the close association of psychiatric and social vulnerability (Jarman et al, 1992; Thornicroft, 1991). Hatfield et al propose that those being assessed under the MHA are not a random reflection of the general adult population, but vary according to key variables that indicate the impact of social factors in the territory of compulsory psychiatric care (see also Barnes et al 1990; Campbell et al 2001; Manteklow et al 2002; Campbell and Davidson 2009). This proposition is strengthened by empirical research undertaken by Hatfield (2008) that provides credible findings about the impact of social factors in relation to people assessed under the MHA. However, the implications raised by Hatfield - that social workers are uniquely placed to recognise and respond to these social issues - is not established by the findings, and is further troubled by the empirical literature, organised in the present review under the heading of 'occupying the social perspective' below.

Hatfield (2008) undertook a study on the social circumstances of individuals assessed by ASWs with the aim of developing a profile of these individuals and identifying changes over a nine-year period. The study sought to answer questions regarding the patterns and trends in relation to the role of the ASW under the MHA 1983 by gathering quantitative data from ASWs applying the MHA in six local authorities in the North of England; this comprised of 14,514 MHA assessments carried out over a nine-year period. The characteristics of the subjects of the research, people assessed under the MHA, are discussed in the study, which highlights the most common marital status for both men and women was 'single'. Women were more than twice as likely to live with partners

or their own children; men were almost twice as likely as women to live with their parents or members of their family of origin, or with other service users in shared accommodation. Indicators of social disadvantage in the study group are revealed in the substantial proportion living in council or housing association property in contrast to the higher proportion of the general population living in owner occupied housing. The proportion of MHA assessments of people already receiving services under the Care Programme Approach (CPA) framework¹ rose steadily over the nine monitoring years from 29.3% in 1996 to 46.7% in 2004. In terms of the outcome of assessments, 73% resulted in detention under the MHA, 10% culminated in informal admission or the continuation of informal status, and in 7% of cases specific alternatives to hospital care were arranged. The remaining assessments resulted in outcomes such as 'advice' or 'consultation'.

In one of the authorities there was an over representation of MHA assessments applied to people described as African-Caribbean (15.5% compared with 2.3% in the census population). This over representation is supported by Webber and Huxley (2004) in the findings of a case control study of emergency admissions under s4 MHA 1983 conducted by retrospective case note review of 300 MHA assessments in two London boroughs, which indicates the most common factors associated with compulsory admission under s4 MHA were presenting with a risk, psychosis and non-White British ethnicity. This corresponds with a large scale quantitative study undertaken by Audini and Lelliott (2000) where 31,000 cases of admission under Part II of the MHA (s2, 3, 4 admissions) were analysed for demographic variables. The findings clearly indicate over-representation of people from Black Minority Ethnic populations being subject to compulsory admission, and suggest that a person from a BME background were six times more likely to be compulsorily admitted under the MHA.

¹ The Care Programme Approach (CPA) was introduced by the Department of Health in 1990 to provide a framework of mental health care for people with severe mental health problems.

In contrast to the impact of social factors linked to 'who' the MHA is applied to, the literature also examines questions about the social context of organisational factors that impact on how the law is used. Furminger and Webber (2009) undertook a study that examined a random sample of MHA assessments conducted in the catchment area of a Crisis Resolution Home Treatment Team (CRHTT). They found that the presence of the team was associated with a significant increase in the use of s2 MHA, although the use of s3 MHA decreased. The aim of the study was to investigate the reasons for the increase to discover the influence of the introduction of the CRHTT on the use of the MHA. Focus groups were conducted to obtain the views of mental health professionals about the reasons for the rise. ASWs expressed the view that some people were assessed for detention because the CRHTT team had refused their referral but they were still at risk of admission. People were also detained because it was becoming increasingly impossible to negotiate informal admission due to having fewer inpatient beds available.

4. Occupying the social perspective

A key debate in the social work literature on how mental health social workers/ASWs/AMHPs use the law relates to a sense of struggle and tension for social work to occupy a robust social perspective, in other words a perspective that can identify and assert social perspectives in the context of competing medical perspectives of mental disorder when using mental health law in practice (O'Hare et al 2013; Campbell 2010). The literature elucidates that this tension is positioned in the context that social work occupies in UK mental health law, where decisions made by mental health social workers are likely to be compromised by organisational and resource implications that reduce the availability of proactive and empowering engagement with service users (Campbell et al 2001; Davidson and Campbell 2007; Campbell 2010; Barnes, Bowl and Fisher (1990), despite Hatfield (2008) proposing a rationale that social workers are uniquely equipped to identify issues in a social context that may contribute to mental health crisis.

The social perspective, which according to the social work literature may be elusive, also appears highly valued. This is elucidated in literature that highlights the contradictory and challenging nature of the phenomenon of using mental health law to take away someone's liberty by members of a profession who profess a commitment to social justice and aspirations to empower service users, containing an appeal to strengthen the social perspective (Campbell and Davidson 2009; Davidson and Campbell 2007; Campbell et al 2006). These ideals are not, of course, necessarily inconsistent with the prospect of detaining somebody in hospital; however, the literature acknowledges a tension here. Occupying the social perspective is acknowledged in the literature as a challenging aspiration, and a distinct social perspective used by the SW/AMHP when applying the law is emphasised, although the empirical literature outlined below questions whether this is what happens and, if it is, how secure this might be. However, one of the few empirical studies that investigated how ASWs and psychiatrists make joint decisions did reveal a clear difference in perception by ASWs who were likely successfully to overrule the decisions of psychiatrists and to view scenarios of admission and discharge using a predominantly social model (Peay 2003). This is also supported by Campbell et al (2001) and Manteklow et al (2002) who found that ASWs in Northern Ireland provided an independent perspective.

This is in contrast with O'Hare et al (2013) who challenge the notion of social work occupying the social perspective when applying mental health law. This was a study that aimed to explore how the core mental health social work role had been affected by the divergence of law and policy that has occurred across the countries of the UK in the last decade. Research participants included mental health social workers, social work students with mental health experience, and AMHPs from England. The study explored views about the context of risk, decision-making and compulsory intervention across the three jurisdictions (England, Wales and Northern Ireland) using survey vignettes and open questions to collect qualitative data on service response in each jurisdiction to explore out how it may or may not have been influenced by the changes in mental health laws and the related policy developments. Key findings suggest a tendency by participants to focus on relapse of psychiatric

symptoms and non-compliance with medication. An over familiarity from the researchers' perspective with medical language is also reported in the study with social workers appearing comfortable using terms such as "command hallucinations", "delusional thoughts", "psychosis", "paranoia", and "psychotic episodes". The implications of this are raised in the study, which questions the ability of social workers to challenge medical discourses. This is also supported by Campbell (2010) and Barnes, Bowl and Fisher (1990), who raise concern that social workers may defer to psychiatric explanations as opposed to drawing on their own understanding.

Understanding the findings from Peay (2003) (consistent with Manteklow et al 2001) in contrast to O'Hare et al (2013), both of which use case study vignettes, requires a consideration of the participants and the contexts in which they were asked to apply decision-making. The ASW participants in the study that focused on duo disciplinary decision-making of both psychiatrists and ASWs (Peay 2003) involved a research exercise where the ASWs were present in a room with psychiatrists in which both parties knew that their decision-making was being investigated. It is likely that the ASWs were aware of their role to bring a social perspective to decision-making under the MHA and applied this in the context of a case vignette. It is also possible that ASW participants were fighting their corner faced with a psychiatrist perhaps with an overtly medical viewpoint. On the other hand, participants may have held a social perspective when it came to understanding the factors surrounding the scenario but if asked to contain the problem in real life would also need overtly to apply the medical criteria adhering to the statutory framework for compulsory detention. The participants in the study conducted by O'Hare et al (2013) were all from a social work background and were asked to return survey data by email; they may therefore have felt less pressure to defend a social position as they completed the survey in isolation from medical colleagues. A further explanation is that, as identified by the authors, the participants in O'Hare et al (2013) also included social work students who are likely to have less experience applying mental health law in practice. A key issue also relates to the type of questions asked, which focused more heavily on perceptions of risk, and recovery models (O'Hare et al 2013) and decisions to admit and discharge

under the MHA (Peay 2003). It is perhaps encouraging in terms of the capacity of AMHPs to occupy a social perspective that this perspective is given emphasis when face to face with a psychiatrist who has an opposing view. These findings suggest that a medical viewpoint might be required to bring out an emphasis on the social perspective by the AMHP. This is consistent with Manteklow et al 2002 who found that 68 percent of ASW respondents surveyed decided not to make an application for detention following receipt of two medical recommendations.

Walton (2000), writing in the context of proposed reform to the MHA 1983, asserts that Approved Social Workers undertake social assessments of mental health crisis and that the main concern of ASWs relates to the social context of mental health, the availability of social resources, civil liberties, and protections for people subject to statutory mental health interventions. In contrast, the dilemma encountered by the ASW in deciding to detain is conceptualised by Thompson (1997) as the balance between self-determination and empowerment, on the one hand, and personal and public safety, on the other, grounded in 'clinical' and legal' knowledge, as opposed to emphasising the importance of the social perspective. Dwyer (2012), in trying to capture the atmosphere experienced by an AMHP in undertaking a MHA assessment, refers to the AMHP as walking a tightrope, providing a pragmatic conclusion about the nature of the perspective brought by the AMHP to a MHA assessment in asserting that detaining someone under the MHA is a judgement call formed by the best assessment in the circumstances where the social worker should bring 'the best of social work values to a troubled person in serious crisis' (Dwyer 2012: 352).

Campbell et al (2006) and Campbell (2010) illuminate the occupation of the social perspective by asserting that conventional assumptions made about mental health social workers' use of compulsory powers in the UK - the assumption that social workers use a social perspective in understanding and responding to mental disorder (see Walton 2000) - have 'tended to be rather one-dimensional and generally unsupported by the evidence base that has

grown in the last few decades' (Campbell 2010:331). Whilst supporting the proposition in the literature that social workers ought to be equipped to recognise and challenge the way that mental health law discriminates against disadvantaged groups in society, Campbell (2010) is less convinced about how such a knowledge base is articulated in practice, calling for explicit recognition of the constraints and limitations placed on social workers.

A further challenge to the ability of the social worker to occupy the social perspective is supported by Barnes, Bowl and Fisher (1990) who, in the context of the ASW role, report that in their use of the MHA 1983 ASWs reinforced gender stereotypes by failing to adequately incorporate social context and social constructs of mental disorder. More recent empirical research further troubles the waters in relation to social work occupying the social perspective, where findings suggest that the notion of the availability of appropriate medical treatment was considered by social work AMHPs as the most significant factor in determining whether compulsory detention was the right thing to do (Buckland 2016).

5.Tensions applying mental health law in practice.

The literature also attempts to shed light on how the law is used in practice by professionals undertaking MHA assessments. The first two studies outlined (Campbell et al 2001; Manteklow,et al 2002) both draw on the first extensive survey of Approved Social Worker (ASW) activity in Northern Ireland, which remains the one of the few extensive studies of this role in the UK. One of the studies focuses solely on AMHP decision-making under the MHA (Buckland 2016); the other four studies involve doctors and AMHPs (or ASWs) (Fistein et al 2016; Quirk et al 2003; Peay 2003; Morgan et al 1999), although one of these studies only managed to conduct an in-depth interview with one AMHP (Fistein et al 2016). This body of literature includes a small number of empirical studies that are closest to my own research question; these are critically interrogated with the aim of highlighting their contribution to answering my research question and to identify any gaps in knowledge, thereby justifying my own research focus.

Campbell et al (2001) and Manteklow et al (2002) draw on an extensive study of ASWs involving a survey undertaken with 243 ASWs (response rate of 84%), focus groups with 30 service users and 6 carers, together with face to face semi structured interviews with mental health service managers. Campbell et al (2001) highlight the complexity of legal and professional functions expected of ASWs, which underlie the inherent tensions of the role. The findings report high levels of perceived competence in relation to knowledge of legal rules reported by practitioners, but some problems in multi-disciplinary working. Interestingly, despite this reported level of competence in applying the law, service users and carers were generally dissatisfied with the responses from crisis services and appealed for adequately funded community supports. The authors conclude that ASWs can perform an important statutory role, adding the important caveat that this is on condition that there is a more consistent approach to training, re-approval and funding of community-based services. Manteklow et al (2002) draw on their extensive study to report on the experiences and practice of Approved Social Workers in Northern Ireland. The authors report interesting findings on the use of law, including problems experienced in communicating with the person assessed. The most common difficulty reported by respondents were problems communicating with the person because they were too disturbed to engage. Trust in the person assessed was also a common issue whereby 40 percent of ASWs reported making applications when the person assessed had agreed to be admitted voluntarily. The authors report several explanations for this: doubts about the reliability of the statement of the person, a history of absconding, and fluctuating mental state. Aggression and threats of violence were common factors associated with the person assessed; in 90 per cent of cases ASWs requested police assistance. Respondents highlighted that the main difficulty in decision-making was a lack of resources other than hospital admission; despite this, 68 per cent did not make an application to detain, a finding that emphasises the independence of the ASW.

Fistein (2016) undertook a qualitative study that aimed to describe how decisions to 'detain' are made under the MHA. The study is set against a backdrop whereby the author highlights a clear tension, described as a 'gap', between policy and practice. Further aims of the study are described as

seeking to understand mental health decision-making and to describe the principles on which decisions to 'detain' are based. Finally, the study explicitly aims to analyse how and why these decisions might differ from the legal framework that defines the circumstances under which lawful detention may take place. Data on how medical practitioners and AMHPs in the East of England made decisions to detain people under s2 or s3 MHA were collected over a 12-month period. The study comprised two methods of data collection. Firstly, what is described as an observational component took place, which was followed by a 15-minute semi-structured interview focusing on the decision-making process involved in the observed MHA assessment. The study involved seven observations of a MHA assessment with fourteen participants: five psychiatrists, five AMHPs, and four general practitioners. Further interviews were conducted -with separate participants to those observed - using a biographic narrative method where participants were asked to recall involvement with compulsory treatment over the course of their working lives and to recall in detail 7 'decisions to detain' made over the course of their working lives. Fifteen psychiatrists and one AMHP took part in these interviews. A thematic analysis (Braun and Clarke 2006) was applied to the data.

The study reports five themes influencing the decision-making: diagnosis, availability of alternatives to detention, likelihood of response to treatment, risk assessment, and the mental capacity of the person assessed to make decisions about treatment. The study suggests that when making decisions about compulsory admission practitioners 'employ their own practical criteria', which are like the provisions of the MHA to some extent but with some important differences between 'policy' (characterized as the MHA legislation) and 'practice' (characterised as the way the MHA is enacted in real-life decisions). The study emphasises the strength of the observational component of the study with the fair claim that there are few direct observational studies into the actual practice of assessing adults for compulsory admission for psychiatric treatment (see Holstein1988, a USA based study, and Quirk et al 2000). A less convincing claim made by the study is that the observational element - a discussion between the practitioners following the MHA

assessment - represents a naturally occurring speech event that forms a basis for the claim that this is the site where the decision happens in real-life.

The narrative interview data were obtained mostly from psychiatrists on their involvement in compulsory admission and 'decisions to detain' over the life of their career. The use of stories about cases has the potential to capture the taken for granted process of these types of decisions; however, there are also limitations in terms of poor recollection of details recalled over the life of a participant's career that may span many years and involve different statutory frameworks. The themes reported comprise overtly medical categories, and it is likely that the fifteen psychiatrists versus one AMHP in the narrative interviews contributed to this.

The tension between what the law says in the actual legislation and how decisions are carried out in practice highlights that the phenomenon of using the law in practice does not fit with a rational/technical or formalist view that envisages legal rules being merely 'followed'. Quirk et al (2003) provide interesting findings from their ethnographic study of MHA assessments. The aim of the study was to describe non-clinical and extra-legal influences on professionals' decisions about compulsory admission to psychiatric hospital. The method of data collection used participants' observation of MHA assessments, including informal and in-depth interviews with the practitioners involved; the study also included follow-up interviews with the people who had been assessed. Data were collected from two London boroughs between December 1998 and July 1999. Approximately eight weeks were spent in each borough shadowing mental health professionals. A strength of this study is the observation of the MHA assessment from the point of referral to the point of conclusion. However, obtaining the experiences of the ASWs in their use of law was not the aim of the study.

The findings report that the chances of being detained under the MHA are likely to increase when there are no realistic alternatives to in-patient care. It is further asserted that this typically occurs when professionals have insufficient time to set alternatives in place and are unsupported by other colleagues in

doing this, and that outcomes may also be affected by local operational norms and the level of professional accountability for specific MHA decisions. It is concluded that non-clinical and extra-legal factors explain some of the geographical variations in admissions under the MHA.

Quirk's study is significant by the fact that it seeks to examine how decisions are made to admit people compulsorily to psychiatric hospital and includes observations and interviews with Approved Social Workers (ASWs). The focus on structural and organisational factors that impact on how the mental health professionals involved make decisions, such as resource constraints or how teams are organised, provides a convincing account capturing some of the factors at play when decisions are made in practice. However, it is also likely that organisational factors other than time impact on the provision of alternatives to hospital admission. The study is explicit in its aims to investigate non-clinical and extra-legal factors, and it is arguable that some of the factors listed as 'extra-legal' factors could be perceived as intra-legal factors. For example, where the study reports that the absence of alternatives to admission to hospital arises because of the ASW exploring alternatives to admission and finding none, this is attributed as representing a 'non-legal' factor influencing decision-making. However, the same scenario could be attributed as being an 'intra-legal' factor, as it seems to show that the ASW was following the statutory duty to 'take into consideration all of the relevant factors of the case' and could be further seen to be adhering to the statutory criteria to 'consider alternatives to detention' both of which are prescribed in the MHA. This represents a trend in the literature to under theorise how law is used in practice.

In common with Fistein et al (2016) Quirk et al (2003) reveal a focus on the primacy of the practical when mental health professionals use the MHA in practice. This pragmatism is viewed by both sets of authors as being representative of a disjunction or a gap between the law in books (MHA statute) and the law in practice.

A focus on the societal context in which AMHPs use the MHA is reported in a qualitative research study conducted by Buckland (2016). The study aimed to

explore the processes involved when AMHPs use compulsory powers, and focused on contextual processes, including how individual values, interpretations of the MHA and contemporary societal discourses were described by participants. Further, the study aimed to have a clear focus on participants' subject positioning rather than on their personal experience or narrative of using the MHA. Face to face semi-structured interviews were employed with ten AMHPs from one local authority area. A Foucauldian discourse analysis was used to analyse the data, utilising a social constructionist epistemological position aimed at exploring how compulsory detention under the MHA is discursively constructed, mapped, negotiated and understood by AMHPs, and drawing on a theoretical perspective that focuses on language, power, and discourse. The findings suggest that individual conceptual frameworks are used by AMHPs to understand mental health and that the appropriateness of available treatments was the most significant factor in determining when the use of compulsory powers was viewed by AMHPs as 'the right decision'.

The question of how non-lawyers make decisions where the legitimacy of those decisions derives from the law was explored by Peay (2003) who carried out a study of duo disciplinary decision-making by doctors and ASWs in 1999. A total of 106 participants took part: fifty-two psychiatrists, fourteen SOADs (second opinion approved doctors), and 40 ASWs. The study used case study vignettes involving admission and discharge scenarios that required the ASWs and psychiatrists to reach an individual decision and then to make a joint decision as to what should happen next. The exercises were not designed exactly to mirror a real-life decision-making setting, but as a device to parallel aspects of a real-life context to facilitate a study of decision-making practices. Participants were sent case histories as part of the case vignette prior to the exercise taking place. Participants were shown a video that represented a picture of the lives and psychiatric histories of the patients represented in the case vignettes. Participants recorded their initial decision on a form that combined potential outcomes and confidence scales. The paired psychiatrist and ASW participants were asked to reach a joint decision and record their individual level of confidence in this decision, followed by participants being questioned about

their decisions in front of each other. The analyses of data used ALCESTE textual analysis of the discussions between ASWs and psychiatrists, which aimed to determine the main word patterns within a text or discourse. Statistical analysis was conducted to investigate the level of agreement in the admission and discharge case scenarios.

The admission scenario illustrates two striking features of the decisions made: first there was a considerable variation in outcomes within and between the ASWs and psychiatrists, where the same case was perceived in different ways and seen as requiring different forms of intervention by different individuals. Secondly, in relation to the difference between individual and joint decisions, the pattern of joint decisions more clearly reflected the decisions the ASWs would have made individually than those of the psychiatrists. An example the study reports is that the psychiatrists' preference for s3 admission was not reflected in the joint decision-making outcomes, whereas the ASWs preference for decisions involving options other than admission was clearly mirrored in the joint decision-making outcomes. The study found that ASWs appeared as a group to have a greater influence on the outcome. A further analysis in the study of 'who wins?' in the discussion revealed that ASWs prevailed on twenty-two occasions, psychiatrists on nine occasions, and for the remaining nine the decision was evenly balanced. The study offers some interesting interpretations of the statistical analysis of the tendency of ASWs to prevail over the psychiatrists, proposing that this does not happen by chance. The interpretation provided, that this is perhaps not surprising, highlights the ASWs' formal role in relation to orchestrating the process of assessment; however, the fact that psychiatrists did occasionally prevail is interpreted as a counter-intuitive finding suggesting that the psychiatrist was able to overrule the decision of the ASW, despite the autonomy and independence of the ASW to make the final decision regarding detention. This finding is further interpreted by the study as posing a question mark over the true multi-disciplinary nature of decision-making. Findings from the 'discharge' decision case vignette also showed marked differences in professional preferences after discussion; for example, most psychiatrists interpreted the information in the case vignette from a medical or disease model, whereas the ASWs interpreted the same

information mostly from a social model.

Differences in the way that mental health professionals from different groups such as psychiatrists and social workers apply the law are not clearly understood. However, there is some indication that findings reported by Peay (2003) may be supported by Morgan et al (1999), who carried out a study of ASWs, psychiatrists, and general practitioners (GPs) using a confidential questionnaire containing fourteen case vignettes derived from real-life situations. The aim of the study was to examine differences in the application of the law between different professional groups. Participants were simply asked if the person described in each case vignette was detainable for admission to hospital under the MHA 1983. The vignettes described cases that involved risk to self, the protection of others and deterioration in health, together with cases where the MHA would be unsuitable, for example in the case of alcohol intoxication. A sample size of sixty-seven was obtained, involving twenty ASWs, nineteen GPs, and 28 psychiatrists. The responses were analysed using Fisher's Exact Test (F.E.T.). Findings suggested significant differences between the different professionals. In general, participants agreed in the cases involving risk to self and risk to others. However, there was less agreement in cases involving 'deteriorating health' where the ASW participants tended to be more reluctant to detain the person; an example of this involved a case scenario of social withdrawal, mutism, and thought insertion elaborated into paranoid schizophrenia. In cases where the application of the MHA would be deemed inappropriate there was also disagreement with GPs willing to use the MHA too readily, for example where detention was requested by a surgeon to perform an amputation. This is in stark contrast to the ASW participants who were inclined towards the opposite extreme with less concern about health grounds. The study is limited in providing statistical outcomes in terms of a dichotomy between 'detainable' or 'not detainable' and as such would not be able to pick up on the process of decision-making elucidated more satisfactorily by Peay (2003). There are further limitations in that participants were unable to choose an option of voluntary admission, a consideration necessary in the application of the MHA in real life. Further evidence of the independence of the ASW is reported above, revealing evidence of the independence of the ASW

(Manteklow et al 2002).

6. Summary of key findings

The key findings from the literature on how social work AMHPs use the law in practice shows that the AMHP role involves the application of law in the social context of feeling stressed and under pressure, although undertaking this role is also considered to be rewarding and an advanced form of social work. Social factors are an important factor in terms of the implication of social disadvantage in terms for *who* AMHPs apply mental health law to. There is a further concerning implication that people from a Black African-Caribbean background are over represented in the use of compulsory mental health powers. Using mental health law in practice is also impacted on by organizational factors involving lack of resources to avoid compulsory admission, including where existing resources do not appear effective in preventing people from being admitted to hospital compulsorily.

A key concept and area of debate in the literature relates to the extent to which social workers/ASWs/AMHPs occupy a social perspective; ambiguity emerges from the literature in terms of what this means in practice. This has major implications for how AMHPs use the law as it raises questions about their autonomy, independence and social lens, all of which are part of their legal mandate. The potential for AMHPs to use the law from such a position does emerge from the literature, notably with research studies that use case vignettes, particularly the studies that involve an interaction with psychiatrists (Peay 2003 compared to Morgan et al 1999). These findings are not consistently established, however, across the small body of literature that focuses on how AMHPs and doctors make decisions under the MHA. Despite the different contexts, the interpretation offered by the studies provides a convincing argument that at the very least whilst there may be spaces and potential for social work to occupy the social perspective in applying mental health law, this is a nuanced and complex position in practice. The conceptualisation of the medical and the social at odds with each other is apparent in the literature and arguably provides a narrow conceptualisation of

the social, focusing on interpretations of the individual features of mental distress and risks, and set up against medical discourses seen as competing with the social. As I will argue later, the medical and the social are not necessarily mutually exclusive and the occupation of the social perspective could envisage a much wider frame whereby the whole process of using the law to respond to mental distress is at its very essence a social perspective.

The review of literature reveals gaps in knowledge about how social work AMHPs use the law in practice. The studies of how decisions are made under the MHA reveal a 'gap' between policy and practice. The phenomenology of using the law in practice is not well understood and is not emphasised in the literature where decision-making from a stand point of a difference between policy and practice is the major area of focus. A further gap in the literature is a lack of emphasis on the entire process of using the MHA in practice when carrying out a MHA assessment, which involves receiving a referral and understanding this with a wide range of people involved. The literature places major emphasis on the 'assessment' under the MHA as a site where 'decisions' are made and located. This does not address the temporal nature of using the law in practice across the whole process, and therefore relationships with people, such as other professionals and the perspectives of the person assessed and family members, are missing from the literature; the socio-relational aspect of using the law in practice is therefore not captured by the literature.

The use of autonomy, independence and a social and medical lens by AMHPs when they use the law in practice is not well understood and there are debates about the extent to which this is possible. These concepts tend to place the medical and the social at odds with each other and there is a need to re-conceptualise these standpoints to capture the 'complex and nuanced nature of using the law in practice' (Braye, Preston-Shoot and Wigley 2011), which includes a need to answer the call for mental health social work to re-conceptualise and face up to the coercive nature of the role (Campbell et al 2006; Davidson and Campbell 2007; Campbell and Davidson 2009; Campbell 2010).

Chapter 3: Theoretical Framework

1. Introduction

This chapter provides an outline of the theoretical framework underpinning the study, used to make sense of the empirical data. The theoretical framework draws on the theories of legal consciousness (Ewick and Sibley 1998; Sibley 2005), street level bureaucracy (Lipsky 1980) and practice theory (Bourdieu 1977, 1997). The notion of 'field' in practice theory is developed by arguing that social work AMHP practice is constructed in the juridical field, drawing on Bourdieu's analysis of the law (Bourdieu 1987). An overview of each theory is provided with application to the study. Finally, I provide a reflection of how each thread of theory is integrated into one theoretical framework before providing a conclusion to the chapter.

2. Theoretical Framework

The question of how social work AMHPs use the law in practice seems easy to answer if one pictures the law and social work AMHP practice as completely distinct, neatly distinguishable entities, the AMHP doing what the law tells them to do by neatly fitting the facts of a given situation encountered into a set of legal rules that focus just on the pathology and characteristics of the individual assessed. This formalistic view of law is however problematic in the context of social work practice because the individuals and situations confronted by AMHPs involve layers of complexity and uncertainty that can defy straightforward determination against legal clauses (Braye and Preston Shoot 1990). Using the law is therefore not that simple; there is more at stake that requires additional considerations alongside rational/technical knowledge of legal rules: 'Competence in practice requires both an acknowledgement of the relevance and applicability of the law and assessment skills inspired by social work values, theoretical knowledge and practice wisdom' (Braye and Preston Shoot 1990: 343; Braye and Preston-Shoot 2006).

Rejection of a formalist view of the law should not fall into the converse trap of perceiving the law as purely instrumental to other forces, including social work AMHP practice. The theoretical framework used to make sense of the empirical data attempts to understand the dynamic interplay between the law and social work AMHP practice, thereby acknowledging the nuance and complexity involved in using the law in social work (Braye and Preston-Shoot 1990; Braye, Preston-Shoot, & Wigley 2011). Both formalist and instrumentalist viewpoints over-simplify the relationship between law and social work by placing them in a dichotomous relationship where, respectively, either the AMHP is perceived simply to follow the law in a relationship where the law is privileged over other considerations in the practice context, or conversely these other contextual considerations are privileged over the law. The theoretical framework used here instead recognises the use of law as a social practice involving participation in a process drawing on habits, dispositions and the art of being able to move forward in a complex practice terrain by turning the action unfolding into meaning, and then meaning into action. Further, the framework is guided by a sensibility to the work of constructing meaning within a field of play where the conditions of the field impact on how the law is used.

Three different theoretical perspectives were used to construct the framework for the thesis and utilised to compensate the limitations of each individually, when applied to the thesis in isolation from the others. No single theory proved enough to form a satisfactory framework on its own. For example, legal consciousness (Ewick and Sibley 1998; Sibley 2005) is the participation and meaning-making in the process of constructing legality, but doesn't address power and hierarchy that occurs inter-professionally, and between patients and families, in the way that Bourdieu (1977;1990) does. Lipsky (1980) attends to the situated practice aspect, which accounts for how AMHPs can't live up to the idealised notion of their role. The theories are linked by providing different focal points within the same lens. Each part of this tri-focal lens performs different functions in relation to understanding.

- Legal-consciousness (Ewick and Sibley 1998: Sibley 2005) deals with micro-level understanding, how the talk, interaction and meaning-making

between people represents the experience of law. This focuses on participation in the process of constructing legality in a MHA assessment.

- Street level-bureaucracy (Lipsky 1980) deals with meso-level understanding of how professionals operate within organisational and institutional constraints. This focuses on how the terrain of social work AMHP practice influences how the law moves from the page of a book to law in action.
- A theory of practice (Bourdieu 1977; 1987;1990) forms a bridge between micro, meso, and macro levels of understanding, accounting for issues of power and hierarchy, which are inherent factors in the use of law in practice by social work AMHPs.

3. Legal Consciousness

The idea of legal consciousness (Ewick and Sibley 1998; Sibley 2005) provides a component lens of the theoretical framework. The concept counters a law-first paradigm - the view that law acts primarily as a tool of public policy designed to achieve pre-established purposes, characterised as law in books. The legal consciousness perspective is concerned with the persistent gap between law in books and law in action; it proposes that a formalist view of law obscures the 'aggregate and cumulative contributions law makes to sustaining a common culture, historical institutions, and particular structures of power and inequality' (Sibley 2005: 2). A legal consciousness perspective includes the relevance of a standpoint that rejects the notion that law is the sole domain of lawyers and legal actors, characterising it instead as participation in the construction of legality and showing interest in how this is produced in everyday practices of a diverse range of actors.

A useful analogy to aid my rationale for drawing on legal consciousness theory in the study is provided by Hertogh (2010) (in Adler 2010 p. 205), who describes how front line officials relate to law from a legal consciousness perspective:

‘On a cold winter’s day, anyone who takes a walk outside immediately realizes the impact of the wind-chill factor. This is the temperature that a person feels because of the wind. For example, a thermometer may only read minus 2 degrees Celsius outside. But when the wind is blowing at 45 km/hr, the wind-chill factor causes it to feel like it is minus 10 degrees Celsius. For a good understanding of the local weather conditions we should therefore take into account both objective and subjective elements. The same holds true for law. If we want to understand the social significance of law, we should not only focus on the law in the books, but also on the way that people experience law. This ‘legal wind-chill factor’ plays a central role in legal consciousness studies.

4. Street level bureaucracy

According to Lipsky (1980), a crucial defining component of street level bureaucrats is that they have discretion in exercising authority. A further key component is that ‘they cannot do the job according to ideal conceptions of the practice because of the limitations of the work structure’ (Lipsky 1980: xvii). According to Lipsky street level bureaucrats occupy a policy making role based upon two interrelated facts: ‘relatively high degrees of discretion and relative autonomy from organisational authority’ (Lipsky 1980:13). The definition of a street level bureaucrat and their policy making role is pertinent in relation to the participants in the study who as social work AMHPs act with autonomy from their employers and therefore fall within Lipsky’s definition (Evans and Harris 2004).

Lipsky (1980) asserts that public policy ‘is not best understood as made in legislatures or top-floor suites of high-ranking administrators’, but in important ways is made ‘in the crowded offices and daily encounters of street-level workers’ (Lipsky, 1980: 7). Street-level workers are the ‘coal-miners of policy’ Maynard-Moody and Musheno (2003: 157): they do the hard, dirty and sometimes dangerous work of the state. This perspective underscores the idea that ‘street-level beliefs are essential to understanding the modern state’ (Maynard-Moody & Musheno, 2000: 333).

Lipsky's (1980) proposition that street level bureaucrats occupy an important place in understanding public policy is based on 'the immediacy of their interactions with citizens and the impact on people's lives' (Lipsky 1980:8). Their decisions are recognised in terms of the profound implications they have on the lives and life chances of people, who 'change as a result of the decisions' (Lipsky 1980:9). In the case of the AMHP participants in the study, the decisions that they describe involve the liberty of people, and as such their use of the law in practice has serious ramifications for individuals assessed under the MHA.

The specific aspects of Lipsky's street level bureaucracy drawn on to contribute to the theoretical framework involve the concepts of the 'social construction of a client' and 'patterns of practice'. Lipsky's construction of a client is relevant to social work AMHPs undertaking their work with non-voluntary service, who are diverse individuals with different life experiences and, in the process of the MHA assessment, reconfigured from 'people into clients, assigning them to categories for treatment... and treating them in terms of those categories' (Lipsky 1980: 59). Attention is drawn here to the unequal relationship between street level bureaucrats and their clients, particularly when they are non-voluntary, which often leads practitioners to perceive the problems experienced by clients as 'calls for categories of action' (Lipsky (1980: 60). Accordingly, practitioners exercise control over clients, which in turn affects the construction of a client; control is exercised by 'structuring the context', the most important feature of which is client interactions: 'when they take place, under what circumstances, with what resources commanded by the parties' (Lipsky 1980:61). Following on from this the assertion is that street level bureaucrats organise the context of decision-making so that they process clients under circumstances most favourable to controlling them.

By definition, people referred for a MHA assessment are non-voluntary, because the MHA assessment is a staging post for considering compulsory admission to a psychiatric hospital for assessment or treatment, in other words admission to a psychiatric hospital without the consent of the person. Notwithstanding this, it is also recognised that the nature of coercion in mental

health services is not confined to compulsory admission to a psychiatric hospital; ordinary every day interactions between mental health professionals and service users can also involve elements of coercion (Davidson and Campbell 2007; Campbell and Davidson 2009). Further relevance of street level bureaucracy to the role of the AMHP is the unequal relationship between an AMHP and a person assessed under the MHA, where the AMHP could be interviewing the person in their home, perhaps having asked police to execute a warrant to force entry in the absence of the person's consent to participate in the process of assessment. More subtle examples of the unequal relationship pervade the relationship between an AMHP and the person assessed (Davidson and Campbell 2007), where regardless of where this occurs - a hospital ward, police station, the street - individual liberty is at stake. The category of action assigned to respond to the problems and situation of the person is a MHA assessment of whether they ought to be detained in hospital. This implicates the AMHP in controlling the client by structuring the context of where, when and with whom the person is assessed; this in turn impacts on the social construction of the person assessed. Social workers in this context are faced with balancing aspects of care with control (Campbell, et al 2001). This balancing act requires AMHPs to develop sound and ethical forms of practice (Campbell, et al 2006) by acknowledging that their interventions are inherently coercive in nature, and often damage the rights of clients and their carers (Manktelow et al 2002; Campbell and Davidson 2009; Campbell 2010). Legal literacy is essential to AMHP practice to 'strengthen their lawful and ethical responses to complex and challenging needs' (Braye, Preston-Shoot and Wigley 2011: 92).

Lipsky's notion of 'patterns of practice' is utilised in the theoretical framework to illuminate how people simplify complexity by creating routines to make tasks more manageable. According to Lipsky street level bureaucrats:

'mentally simplify the objects of perception to reduce the complexity of evaluation. They structure their environments to make tasks and perceptions more familiar, less unique. Routines and simplifications aid the management of

complexity; environmental structuring limits the complexity to be managed' (Lipsky 1980:83).

Patterns of practice are relevant for social work AMHP participants in the study as their work involves an expectation to 'categorize' clients; here Lipsky points out that 'the extent to which they are open to fresh information contradicting facile categorization also is not predetermined' (Lipsky 1980: 85). This is particularly relevant to AMHPs using the law where:

'they are generally obliged to make decisions based on the available evidence rather than presumptions of proper determinations. They are obliged because they have been assigned profound responsibilities concerning the liberty of citizens or the fate of people regarded as incompetent and unable to act in their own best interests' (Lipsky 1980: 85).

Lipsky's work highlights the dynamic interaction between the client and the AMHP and the 'processing nature' of that interaction from the perspective of the AMHP. Lipsky captures some of the realities of social work AMHP practice such as having to do one's best in difficult circumstances and that aspirations of how things should be done are not always realised in practice (Campbell and Davidson 2009; Campbell 2010; O'Hare 2013; Preston-Shoot 2010). What Lipsky does not do with street level bureaucracy is provide a deeper theoretical perspective that might explain this type of human action. However, Bourdieu addresses this with his theory of practice.

5. Bourdieu's theory of practice

A further important theoretical lens framing the study draws on Bourdieu's theory of practice (Bourdieu 1977;1987;1990). The strength of Bourdieu's work for this application lies in his approach towards a theory of practice that transcends dichotomies; it is therefore utilized as a way of illuminating how the law is used in social work AMHP practice, sensitizing analysis to the dynamic interplay between the world of law and the world of practice. Bourdieu's practice theory is particularly useful in application to the study of how social work AMHPs use law because it is concerned with human action as practice,

acknowledging that human action is regulated and patterned without strict obedience to external structures such as rational calculation of legal clauses. The relevance of this lies in its acknowledgement of the nuance and complexity involved when social work AMHPs use the law (Braye and Preston-Shoot 1990; 2005; Braye, Preston-Shoot and Wigley 2011; Brophy and McDermott 2013; Courtney and Moulding 2014; Davidson, Brophy and Campbell 2016). Here I outline how Bourdieu defines the key concepts of habitus, capital, and field, and elaborate on these with specific reference to the juridical field, which I argue is the field of play where social work AMHP practice is situated.

5.1 Habitus

Bourdieu's concept of habitus attempts to understand human practice by transcending dichotomies such as past, present and future, and structure and agency. I propose that this approach may similarly enable analysis to move beyond the dichotomy often drawn between law and social work practice.

The genesis of Bourdieu's concept of habitus is illuminated by Grenfell (2008): 'Bourdieu asks how social structure and individual agency can be reconciled and how the outer social and inner self help to shape each other' (Grenfell 2008: 50). Bourdieu defines habitus as a property of social agents that comprises a 'structured and structuring structure' (Bourdieu 1994:170). The structured nature of a person's habitus is attributed to their current and past situation including their education, profession, family background, and experiences. Habitus is dynamic in the way it influences and shapes human practices, yet the structure of habitus captures the idea that it is formed by 'dispositions that generate perceptions, appreciations and practices' (Bourdieu 1990: 53). Disposition is an important component of the habitus because it bridges the outer social and inner self. Bourdieu defines disposition as:

'expressing first the result of an organizing action, with a meaning close to that of words such as structure; it also designates a way of being, a habitual state and, in particular, a predisposition, tendency, propensity or inclination' (Bourdieu 1977:214).

Habitus is elucidated in Bourdieu's 'force of law' (Bourdieu 1987: 811) as:

'...the habitual, patterned ways of understanding, judging, and acting which arise from our particular position as members of one or several social "fields," and from our particular trajectory in the social structure The notion asserts that different conditions of existence—different educational backgrounds, social statuses, professions, and regions—all give rise to forms of habitus characterized by internal resemblance within the group and simultaneously by perceptible distinction from the habitus of differing groups.'

The role of habitus in relation to social work and the use of coercive powers contained in mental health law is implicitly recognised in the situated approach to ethical decision-making taken by Davidson and Campbell 2007 (see domain 1 the personal and inter-personal).

In Bourdieu's theory of practice, dispositions require resources, which take the form of different types of capital. Bourdieu's notion of capital is outlined below with relevance to the AMHP role, focusing on capital accumulated over the course of a career.

5.2 Capital

Bourdieu proposes that capital presents itself in three main forms: economic capital, cultural capital, and social capital. The form that capital takes depends on the field in which it functions (Bourdieu in Richardson 1986). AMHP practice in the juridical field implicates social capital as the most relevant form of capital at play because the resources of power drawn on by an AMHP involve socially constructed legal texts and social relations with other professionals, family members and the person assessed. Credentials such as being a section 12 approved doctor (s12 MHA), being a nearest relative (S26 MHA), or being categorized as suffering from a mental disorder (S1 MHA) are important aspects of social capital. Social capital is defined by Bourdieu as: 'membership in a group which provides each of its members with the backing of the collectively owned capital, a credential which entitles them to credit...' (Bourdieu in Richardson 1986:249). The way that social capital manifests is

defined by Bourdieu as ‘made up social obligations (“connections”) that are convertible, in certain conditions, into economic capital and may be institutionalised in the form of title or nobility’ (Bourdieu in Richardson 1986:243). Bourdieu argues that title or nobility as represent ‘symbolic capital’ defined as ‘...apprehended symbolically, in a relationship of knowledge’ (Bourdieu in Richardson 1986: 255). For the purposes of this study, relevant forms of symbolic capital include the credentials of being qualified as an AMHP, which entails knowledge of the law and being ‘warranted’. A further important aspect of symbolic capital with relevance to the AMHP role involves the important concept of autonomy that enables the AMHP to employ a social perspective in contrast with the medical perspective employed by the doctors involved in a MHA assessment. The power resource attached to this specific symbolic capital carries with it the final decision on whether someone should be detained, linked to the recommendations underpinned by the knowledge of the doctors involved. A further important aspect of symbolic capital is attached to the AMHP using the law autonomously, not under the direction of their employer or any other party. The ultimate symbolic capital is attached to the constitutive power of law, that is, the power of law to name. This provides symbolic capital to an AMHP as a resource to categorize whether someone is detainable, or not, under the MHA.

Habitus draws on capital to generate action within specific social contexts. A fundamental part of how habitus works is in the dynamic relationship with another central concept proposed by Bourdieu: field. It is the relation between both habitus and field that is fundamental for understanding practice.

5.3 Field

Bourdieu’s concept of field refers to the significance attached to the social spaces where human practice occurs. Whereas habitus refers to subjectivity, or a feel for the game, field refers to the objective conditions of practice. These social spaces are not benign social spaces but rather are characterised as force fields, or fields of knowledge.

Bourdieu (1987; 1990) describes the field as representing social practice in terms of a game where players have structured set positions with rules that are learnt. The concept also captures the idea that actual conditions of the field also impact on the way that the 'game' is played. The analogy of a football field captures the idea of a competitive social space where players compete for control. The idea of a force field captures the powerful magnetic pulls that occur within these social spaces. Bourdieu considered that the social world was made up of multiple fields and that they could interact simultaneously and overlap (Thomson in Grenfell 2008). However, Bourdieu considered that some fields were more powerful or dominant than others; this leads me to identify Bourdieu's juridical field as the field that is in play when social work AMHPs use the law. The juridical field captures the idea proposed by Bourdieu that the law is 'special' in comparison with how other fields operate. Bourdieu's analysis of the juridical field (Bourdieu 1987) is drawn on below to contribute to the theoretical framework of the thesis.

5.4 The force of law

Terdiman elucidates Bourdieu's conception of the juridical field in the introduction to 'The Force of Law' as 'an area of structured, socially patterned activity or "practice," in this case disciplinarily and professionally defined' (Terdiman in Bourdieu 1987: 805). The 'field' and the 'practices' that occur within it are described by Terdiman as:

'...broadly inclusive terms referring respectively to the structure and to the characteristic activities of an entire professional world. If one wanted to understand the "field" metaphorically, its analogue would be a magnet: like a magnet, a social field exerts a force upon all those who come within its range. But those who experience these "pulls" are generally not aware of their source. As is true with magnetism, the power of a social field is inherently mysterious. Bourdieu's analysis seeks to explain this invisible but forceful influence of the field upon patterns of behaviour—in this case, behaviour in the legal world' (Terdiman in Bourdieu 1987: 806).

Using the law in social work AMHP practice is behaviour in the legal world and therefore occurs within the juridical field. Bourdieu attempts to avoid the dualistic notions of law portrayed by formalism without succumbing to an instrumentalist view:

‘...it is necessary to realize that these two antagonistic perspectives, one from within, the other from outside the law, together simply ignore the existence of an entire social universe (what I will term the "juridical field"), which is in practice relatively independent of external determinations and pressures. But this universe cannot be neglected if we wish to understand the social significance of the law, for it is within this universe that juridical authority is produced and exercised. The social practices of the law are in fact the product of the functioning of a "field" (Bourdieu 1987:816).

Bourdieu proposes that the magnetic pull of the legal field requires that those experiencing the pull (a legal professional, civil litigant, criminal defendant, or other legal actor such as a social worker using the law) accept the authority and jurisdiction of the law: in other words, accepting the legal rules that apply in a specific context, for example in legislation, case law, and codes of practice that structure the landscape of social work AMHP practice. This is an important consideration for this study because knowledge of the law is core to social work practice (Braye and Preston-Shoot 2016, Johns 2016) and the AMHP role is mandated by law (Campbell 2010). Notwithstanding the acceptance of the rule of law, Bourdieu asserts that social practices, whilst not explicitly recognised, are deterministic of how the law really functions:

‘Entry into the juridical field implies the tacit acceptance of the field's fundamental law, an essential tautology which requires that, within the field, conflicts can only be resolved juridically-that is, according to the rules and conventions of the field itself’ (Bourdieu 1987:831)

Bourdieu's conception of the social practices that underpin how the law functions is based on the premise that practices structured by law are ‘patterned by tradition, education, and the daily experience of legal custom and professional usage’ (Terdiman in Bourdieu 1987: 807). These manifest as

structured and structuring dispositions within the juridical field, characterised in Bourdieu's terms as 'habitus'. For Bourdieu, the social practices inherent within the juridical field are unlike the practices of any other social field. This is based on recognition of the constitutive power of law, representing the power of law to profess impartiality and neutrality:

'These performative utterances, substantive—as opposed to procedural—decisions publicly formulated by authorized agents acting on behalf of the collectivity, are magical acts which succeed because they have the power to make themselves universally recognized. They thus succeed in creating a situation in which no one can refuse or ignore the point of view, the vision, which they impose' (Bourdieu 1987: 838).

Bourdieu elaborates on the significance of the constitutive power of law where he characterises law as:

'Law is the quintessential form of the symbolic power of naming that creates the things named, and creates social groups in particular. It confers upon the reality which arises from its classificatory operations the maximum permanence that any social entity has the power to confer upon another, the permanence which we attribute to objects' (Bourdieu 1987: 838)

This provides the social practices with a powerful dynamic influence to determine the application of law, for example to decide whether someone is detainable or not under the provisions of the MHA. This is a basis of the rationale for conceiving social work AMHP practice as occurring within the juridical as opposed to any other field, for example the bureaucratic field. It is however recognised that the juridical field in the context of social work AMHP practice is closely tied to other social fields, albeit this relation to other fields resistance and struggle against different forms of social practice.

Bourdieu conceives a social field as a site of struggle where players compete for control. Terdiman (in Bourdieu 1987: 838) highlights the significance of the field in constituting what is controlled:

‘...it locates the issues about which dispute is socially meaningful, and thus those concerning which a victory is desirable.’ This struggle for control leads to a hierarchical system within the field—in the case of the juridical field, to a structure of differential professional prestige and power attaching to legal subspecialties, approaches, and so on. This system is never explicitly acknowledged as such.’

This sheds light on who might be conceived of as competing against whom in the context of a MHA assessment. The MHA itself and code of practice pit these ‘perspectives’ in opposition.

Bourdieu’s juridical field also illuminates the relevance of the practical nature of the use of mental health law in practice proposed by previous studies outlined in the literature review (Fistein, et al 2016, Quirk, et al 2001); however it does so by acknowledging that the ‘practical’ is the essence of using the law in practice as opposed to representing a moulding or discarding of the law in preference to practical circumstances inherent in the territory of the real world where law is used to respond to human problems. Bourdieu elaborates that:

‘Unlike literary or philosophical hermeneutics, the practice of interpretation of legal texts is theoretically not an end in itself. It is instead directly aimed at a practical object and is designed to determine practical effects. It thus achieves its effectiveness at the cost of a limitation in its autonomy. For this reason, divergences between "authorized interpreters" are necessarily limited, and the coexistence of a multitude of juridical norms in competition with each other is by definition excluded from the juridical order’ (Bourdieu 1987: 818)

Drawing on Bourdieu’s juridical field also sheds some light on the way that the law is used to respond to problems where the game is already in play at the point of the AMHP receiving the referral and where the field of play structures the response to the individual. Bourdieu highlights that:

‘In short, the power of the professionals is to manipulate legal aspirations—to create them in certain cases, to amplify them or discourage them in others. The professionals create the need for their own services by redefining problems

expressed in ordinary language as legal problems, translating them into the language of the law and proposing a prospective evaluation of the chances for success of different strategies' (1987: 831).

I have provided definitions of Bourdieu's key concepts of habitus, field and capital, which are inter-related components of the theoretical framework used to make sense of the empirical data. I now turn to integrating Bourdieu's approach with application to the question of how AMHPs use the law.

6. Integrating Bourdieu with AMHP use of law

The starting point for integrating Bourdieu's thinking, outlined above, to AMHPs' application of the law is in relation to his theory of practice, which accordingly rejects a purely rational/technical or calculative explanation for how AMHPs use the law. Bourdieu's approach acknowledges that social practices are messy and cannot be accounted for by a model that determines human action as purely rule-bound. Social work use of the law is more nuanced and complex than this (Braye, Preston-Shoot and Wigley 2011) and AMHP practice requires a more situated approach to how the law is used (Davidson and Campbell 2009). Bourdieu's thinking is particularly useful to a study of how AMHPs use the law because his theory of practice acknowledges the dynamic interplay of structure and agency without reducing either to a dichotomy. I argue that this is a useful way to conceptualise the relationship between law and social work AMHP practice because it accounts for the embodied and unconscious practices of using the law where AMHP dispositions enable them to use the law like a fish in water in the sense that they are attuned to the rules of the game.

'Habitus' provides a way of understanding how social work AMHPs use the law by shining a light on the way that interests, dispositions, experience, and know-how are involved in a dynamic interplay with resources of power such as professional titles and qualifications and legally prescribed roles and definitions. Finally, Bourdieu's thinking illuminates the significance for how the law is used by AMHPs of the conditions of the field of play where practice takes place. This resonates with the present study because the structural conditions

encountered by social work AMHPs in practice are likely to have an impact on how the law is used (Preston-Shoot 2010a; 2010b; Campbell and Davidson 2009; Davidson and Campbell 2007; Campbell 2010; Davidson, Brophy and Campbell 2016).

7. Integrating theoretical perspectives into a framework

The theories introduced in this chapter are woven into a framework that provides a foundation for the entire study. The theoretical threads drawn on comprise of legal consciousness (Ewick and Sibley 1998; Sibley 2005) street level bureaucracy (Lipsky 1980), and Bourdieu's theory of practice (Bourdieu 1977; 1987; 1990). The elements of each are outlined with application to the study, providing a rationale for the choice in building the theoretical framework.

Legal consciousness

The rationale for drawing on legal consciousness (Ewick and Sibley 1998; 2005) to build the theoretical framework is that this theory troubles the water on a formalistic view of the law by acknowledging and valuing how law is experienced by both legal and non-legal actors, and in doing so enables a more nuanced understanding of how the law is used by AMHPs. A fundamental contribution of legal consciousness to the study is the acknowledgement that the social significance of law needs to focus not only on the law in books but also on the way that people experience the law. Ewick and Sibley (1998; Sibley 2005) define legal consciousness as participation in the process of constructing legality; in other words, use of the law in practice does not exist in a vacuum. It involves the AMHP participating in the social process of deciding how the law applies. Further rationale for drawing on legal consciousness to build the theoretical framework lies in its key recognition that law also permeates beyond explicit legal clauses. When applied to social work AMHPs using the MHA in practice this means that, from a legal consciousness perspective, the entire process of a MHA assessment is characterised as using the law. For example, the AMHP thinking about a referral in their car on the way to the assessment, bringing to their mind the description of mental disorder

in a referral, arranging an independent doctor to take place in the assessment, or knocking on the door of the address where a MHA assessment is to take place, all constitute using the law. 'The law is all over' (Sarat 1990:343).

Street level bureaucracy

The rationale for drawing on street level bureaucracy (Lipsky 1980) to build the theoretical framework is the recognition that the best way to understand how social work AMHPs use the law is at street level where decisions are made. Further, street level bureaucracy acknowledges that in many ways the experience of policy at street level is where policy is actually made. Further rationale underpinning this choice relates to the recognition by Lipsky (1980) that street level bureaucrats balance the benefits of discretion with the burden of carrying out their work in conditions that prevent them from realising the ideal conceptions of their practice; this resonates with studying how social work AMHPs use the law in practice (Campbell et al 2001;2006; Campbell 2010; Manteklow et al 2002; Braye and Preston Shoot 1990; Preston-Shoot 2010a; 2010b).

Further contributions made by street level bureaucracy to building the theoretical framework relate to Lipsky's (1980) thinking about the social construction of a client and patterns of practice that acknowledge the role of agency in terms of reducing complexity within the structured constraints of practice. The resulting categories of action, such as whether, or not, someone is detainable under the MHA, are used to respond to service users with diverse needs.

A theory of practice

Bourdieu's theory of practice (Bourdieu 1977; 1990) is particularly useful for understanding human action as embodied practice that is both patterned and regulated, without being rational and calculative. This fits well with a study of how AMHPs use legal rules that can account for the nuance and complexity involved when using the law in practice (Braye, Preston-Shoot and Wigley

2011). It provides a theory that acknowledges socio-relational processes that involve a complex interplay between subjective world of AMHPs with objective conditions of the field of practice. Bourdieu's theory of practice is drawn on because it attempts to transcend dichotomies such as structure and agency, or law and social work AMHP practice, whilst acknowledging the powerful structural forces that interact with and form practice.

When taken in isolation, no single part of the theoretical framework provides a sufficient understanding of AMHP practice. However, when integrated, the whole framework outlined above is greater than the sum of its parts. The individual parts of the framework are linked by the nature of the AMHP task, drawing on legal consciousness (Ewick and Sibley 1998; Sibley 2005) applied to the task of participation in a process that is permeated both by law and the conditions of practice. Street level bureaucracy (Lipsky 1980) provides a further layer of understanding of the balance between discretion and the burden of not being able to carry out their task in accordance with ideal conceptions of practice, and of how the complexity encountered by AMHPs in a MHA assessment is reduced by employing strategies to socially construct the client and patterns of practice. A further layer of understanding on the AMHP task is provided by practice theory (Bourdieu 1977;1987;1990), which proposes that the AMHP task requires the AMHP to draw on habits and dispositions to navigate their use of the law.

8. Conclusion

I have outlined the elements of the theoretical framework that I employ to explore how law is used in the open systems of social work practice: legal consciousness (Ewick and Sibley 1998, Sibley 2005), street level bureaucracy (Lipsky 1980), and Bourdieu's key concepts of habitus, field and social capital (Bourdieu, 1977, 1987, 1990). I have highlighted that social work AMHP practice occurs in the juridical field. I have provided definitions of these concepts and highlighted the relevance of them in terms of a lens to make sense of the empirical data from the study. I have also provided an integration of Bourdieu's thinking with application to AMHP use of law and integrated the

various threads of theory into a theoretical framework that underpins the study. In the following chapter I provide details of methods and methodology employed in the study.

Chapter 4: Methodology

1. Introduction

This chapter discusses the methodology of the study. The methodology and the identity of the researcher are implicated and inextricably linked in the study. Therefore, the study does not under-play the researcher position within it. The chapter begins with a discussion on practitioner/researcher identity, then outlines the ontological and epistemological stance of the study, the research strategy and finally, ethical issues. I have followed the approach of Wolcott (2009), presenting the methodology as a 'personal narrative through which you introduce the study in the manner that it was experienced, reaching as far back as you feel necessary to put things in context' (Wolcott, 2009: 25).

2. Practitioner/researcher identity

2.1 Reflexivity

Representing the research process and my identity in it is challenging because of competing imperatives: on the one hand, telling the story to the reader in a linear format, and, on the other, trying to represent coherently a messy, iterative, spiralling process that occurred over several years. Pryor and Ampiah (2004:167) refer to this as the double crisis of representation and legitimation, within which taking a narrative approach affords the possibility of 'fluidity within coherence' (Pryor and Ampiah 2004:167 in Dunne, Pryor and Yates 2005) and thereby doing justice to the complexity of methodology. To make my way through this challenge I attempt to make a connection between methodology and my researcher identity. This involves owning up to problems and the tensions within my position as a researcher and practitioner, and 'working on the spaces in between them' (Dunne, Pryor and Yates 2005: 172).

Willig (2013) characterizes the concept of reflexivity as an awareness of the

researcher's contribution to the construction of meanings over the course of the research and an acknowledgement of the impossibility of remaining outside and completely objective of the subject matter while conducting research. This chapter therefore is written with the recognition that personal and epistemological reflexivity form an integral part of the research process (Willig 2013).

2.2 Influence of my practice on the research

Trevillion (in Shaw, et al 2009) emphasises that the relationship between research and the practice contexts in which it takes place is one of the most important and yet poorly understood issues facing social work, highlighting that little is known about the way that practice influences research. The influence of my social work practice on my research can be traced to when I qualified as a social worker, and the connection continued to develop over the course of my post-qualifying career as an Approved Social Worker where I experienced, through applying the MHA in practice, how my use of law had major implications in relation to individual liberty. I also experienced how indeterminate the law could be in practice and was aware of how the circumstances surrounding a person, such as the way that their experiences of mental distress were perceived by and impacted on others, could significantly determine whether the MHA was brought into play at all.

I also became more aware through my practice that the use of the MHA could not be reduced to a simple equation involving a rational/technical application of knowledge of legal rules applied to the circumstances of a case. Later in my role as a researcher alongside my role as a practitioner I began to think of this 'law first' perspective as being unsatisfactory to account for how the law was used in practice. The use of law in my experience seemed to be much more complex than could be accounted for by a notion of simply following the law to get to the best outcome. I had a sense that when I was applying the MHA there were many more contingencies at play in deciding whether-or not someone ought to be detained. I therefore began to think more critically about how law is

used. The complex terrain of *using* the law (Braye and Preston-Shoot 1990; Braye and Preston-Shoot 2005; Preston-Shoot 2010a; Preston-Shoot 2010b) stimulated my interest in attempting to open the black box of the nuanced and complex relationship between social work and law in the field of involuntary admission to hospital under the MHA (Braye, Preston-Shoot and Wigley 2011; Campbell, et al 2001; Manteklow, et al 2002). This coincided with discovering the work of Lipsky (1980), which provided a way of thinking about the significance of the work involved in applying the law at street level, together with an appreciation that the conditions of practice shape and are shaped by this.

I came to the research study after almost ten years of practice as a mental health social worker and at the point of submission of my doctoral thesis was fifteen years in practice, thirteen as a combination of ASW (until 2008) and then an AMHP. Thus, I came to the research with a standpoint. This standpoint recognizes and grapples with competing tensions, accepting that some people in limited circumstances will need to be detained under the MHA for assessment or treatment of mental disorder as a last resort, whilst recognizing that this can have both harmful and beneficial outcomes for people. This standpoint also recognizes that, in many cases, the detention of a person in hospital represents a failure by agencies to respond effectively and earlier before things reach the point where detention in hospital becomes the answer. This standpoint was involved in the evolution of the research study, impacting on the questions I asked, the choice of focus on AMHP participants, the design of the research, my analysis of the data and presentation of it. Notwithstanding the recognition of my role as a practitioner on the research study, it is important to note that I did my best to apply the research methods diligently, aware of the need to apply the skills of a researcher to my field of practice. Therefore, recognizing and highlighting the fluid and dynamic implications of being both a researcher and a practitioner owns up to the undeniable positionality involved in the research study by implication of my practitioner standpoint, whilst making clear that this did not mean that my practitioner identity was privileged over the need to apply the knowledge and skills of a researcher.

My observations and experiences of the MHA assessment in practice were that AMHPs knew what to do and how to make sense of what was happening, and could move through the process of undertaking an assessment with what appeared to be tacit knowledge of the law and how to apply it. It was the craft and disposition of the AMHP using the law in the complex terrain of practice that interested me and underpinned my research question. The research question was further framed by a theoretical lens incorporating Ewick and Sibley's concept of legal consciousness (Ewick and Sibley 1998; Sibley 2005), Bourdieu's theory of practice (Bourdieu 1977; 1987; 1990) and Lipsky's street level bureaucracy (Lipsky 1980), as outlined in chapter 3.

2.3 Influence of the research on my practice

My journey as a practitioner was also grounded in the research journey. Whilst undertaking the research I found that I became more aware and critical of the role of the MHA in practice and developed a heightened sense of the constitutive nature of law (Bourdieu 1987; Ewick and Sibley 1998; Sibley 2005; Lipsky 1980). Engaging with the literature on social work and law resonated with my experience of practice: that using the law was not as simple as applying legal clauses to the complex needs of individuals and situations that I encountered when using the MHA (Braye and Preston-Shoot 1990; Braye and Preston-Shoot 2005; Braye, Preston-Shoot and Wigley 2011), and that using the law as a social worker can be enhanced by engagement with the idea of legal literacy: seeking a balance between doing things right, doing right things and rights thinking (Braye and Preston-Shoot 2006b, Braye, Preston-Shoot, and Wigley 2011, Preston-Shoot and McGill 2012). As the theoretical stance deployed in my research developed, I began, at times, to catch glimpses of my practice through a similar lens, reflecting how elements of theory resonated with my experience in practice. This gave rise to a critical reflection on my practitioner role that involved a persistent desire to search for deeper understandings of how I used the law as an AMHP. The impact of my research on my practice has also involved a search for relevance to the people I assess.

Whilst I changed the way that I thought about how I used the law in practice, I still made applications to detain people under the MHA. I was becoming more aware of the need to look at things differently in terms of how the MHA is used and at the same time experiencing the challenges of putting this into practice (Davidson and Campbell 2007; Campbell and Davidson 2009; Davidson, Brophy and Campbell 2016). I became more convinced that my habits, dispositions and position as a practitioner needed to be problematized with the aim of improving my practice to re-align the coercive nature of practice in this area, in order to empower those being assessed as much as possible (Campbell 2010; Davidson, Brophy and Campbell 2016), whilst from my professional perspective I acknowledged that sometimes, in very specific circumstances, people with mental health problems will need to be detained under the MHA. The questions for my own practice that arose during the research journey involved trying to unpick the conundrum: how does an AMHP use the law to potentially take away the liberty of someone whilst at the same time empowering them? How can coercion be used in a recovery-based way that promotes shared decision-making with service users? How can I embrace the challenges in taking a more recovery-oriented approach given the competing risk-oriented approaches? (Davidson, Brophy and Campbell 2016).

2.4 Insider/outsider identity

I have been a mental health social worker for the last fifteen years, an AMHP for the last thirteen. Before that I worked as a support worker in mental health in the 1990s, when the asylums were closing and long stay patients re-entered the community after years shut away. Seeing this move from the asylum to the community and later becoming AMHP in a role where I was taking people back to hospital from the community undoubtedly led to my research interest in AMHP decision-making on admissions. My standpoint is cut through with this professional identity; inhabiting this professional role brings with it a certain way of looking at the world, for example privileging social perspectives, understanding people in the context of their experiences and environment, grappling with coercion and care, and justifying state intervention in the lives of

others. A social work perspective is therefore unavoidably present at every stage of the research and my representation of it. A researcher from a different professional background, for example a psychologist, nurse, psychotherapist or psychiatrist, would arrive at different understandings of the data based on their own standpoint. This is a piece of social work research, undertaken by a social worker. I am an insider researcher, owning all the advantages and disadvantages this brings to the research. 'Insider' refers to someone who is part of a community of practice undertaking research within their organization or community of practice (Drake and Heath 2011), whereas the notion of an outsider implies that the researcher comes to the research setting without being part of the organization or community of practice. Belonging to the same community of practice, occupying the same professional role as participants, placed me firmly in the role of an insider-researcher. This has implications for how I represent the participants in the study because the participants mirror my own professional image. The inherent tensions that exist in the position of an insider researcher occasionally led me to claim that the insider-outsider paradigm was dynamic and shifting as opposed to experiencing a fixed static identity throughout the process of the research (Morris 2015; Savvides et al 2014). However, in the final analysis this representation is erroneous. This search for a way out of being an insider occurred because, at times, I tried to distance myself from my professional social work/AMHP identity, seduced by the promise of objectivity. To be clear, my position in the research is an insider-researcher. In the end, owning up to my insider identity was a necessary step towards a more rigorous and reflexive methodology.

Practical issues came to the fore early in the transition from learning about how to do research to the reality of planning to undertake it. A significant issue that arose was the contrast of my identity and role as a novice researcher with my identity and role as an experienced social worker and Approved Mental Health Professional in my organisation. Revealing myself as a researcher to practitioner colleagues with whom I worked felt daunting and undoubtedly this dynamic ran uncomfortably at times alongside the process of learning how to undertake research and applying this in the field where I practise.

The journey of undertaking the research and writing about it coincided with moving from one AMHP role to another, and then involved moving to a lecturer post at a university at the writing up stage whilst retaining employment with the local authority as an out of hours AMHP. Hellowell (2006) suggests that there are subtle and varying shades of insiderism and it can sometimes become apparent 'that the same researcher slides along more than one insider-outsider continuum', and in both directions during the research process' (in Drake and Heath 201:26). My own experience was similar in that I experienced fluid shades of insider-outsider identity that slid along a continuum influenced by different spaces and time that I occupied during the research process.

The implications of inhabiting this insider/outsider status involved both challenges and opportunities. Opportunities involved access to research participants who may otherwise have been reluctant to be interviewed and, notwithstanding this, may have been reluctant to talk openly about assessments. My insider status enabled access and a peer relationship seemed to enable participants to feel comfortable talking openly about assessments. This challenge therefore provided the opportunity to gain rich data. Conversely, this also raised challenges in how participants and I took for granted things that were both said and un-said during the interview because of our immersion in the field of practice under exploration. Further challenges arose when analysing and representing the data obtained. My research question focuses on my area of practice; this led to the danger of drawing on my own experience to make sense of the data. Research supervision enabled me to challenge my own thinking and involved a diligent effort to represent the findings as accurately as possible. Occupying a different space on the insider/outsider continuum when moving to a part-time out of hours AMHP role alongside a lecturer post enabled a fresh perspective on the AMHP role, and space away from practice to think about how to represent the data.

2.5 Researcher and respondent power dynamics and ethics

The methods used in my research (shown later in this chapter) were qualitative interviewing and practitioner diaries. This gave rise to practical and ethical issues as an insider researcher, resulting from the implicit power asymmetry between interviewer and interview participants. In the case of my research some interview participants from one of the boroughs where fieldwork took place were also colleagues. The interviews were conducted and constructed according to my methodological stance and specific interests, and I interpreted the interview participants' answers; all this tips the balance of power towards the researcher as opposed to the researched (Kvale 2009). I attempted to address the balance of power, for example by making it explicit that participants were free to withdraw at any time without explanation.

This explicit acknowledgement of power dynamics provided the opportunity to explore the boundary between myself as an interviewer and my participants as interviewees and brought home the importance of explicitly addressing this in how the text arising from interviews is dealt with in the analysis and writing up.

3. Ontology and Epistemology

My ontological stance, concerned with the nature of the world, underpinning the research is social constructionism (Berger and Luckman 1966), which proposes that reality is not naturally given. A social constructionist ontology applied to the research views the social phenomena of AMHPs using the law as a mode of reality that is, following Searle (1995), epistemologically objective in that the MHA exists and constrains the lives of some people, but requires human practices to exist, and ontologically subjective in that without human agreement or construction, there would be no MHA. This stance recognises that:

‘These institutions, originally created by people, by and by begin to be perceived as something external, objective, and given, that is, there occurs also an *externalization* and an *objectivation* (Berger and Luckman 1966: 78).

The study focuses on AMHPs describing how they use the law. The relevance of a social constructionist ontological perspective here is that it avoids a hard

determinism, which posits that it is possible to have objective and certain knowledge that can obtain a 'correct' view of the world. This ontological stance would be inappropriate for what I want to find out because of the nature of the social phenomena that my research focuses on, which take place in an open system, and where the research project explicitly involves a theoretical approach that places an emphasis on the indeterminate and constitutive nature of law.

My epistemological position, concerned with knowing and learning about the social world, can be best described as interpretivist. According to Orme and Shemmings (2010) 'interpretivism suggests that knowledge is concerned with interpretation, meaning and illumination. Human action is given meaning through interpretation and researchers have to make sense of how people make sense of the world' (Orme and Shemmings 2010: 88). Accordingly, and in contrast to positivism, my position is that it is not possible to conduct objective, value-free research. The positive value of this approach to my research lies in the importance that it gives to meaning in terms of illuminating how AMHPs *understand* the Mental Health Act 1983 and their use of it.

The nature of the phenomenon that the research explores involves me trying to capture the complex and nuanced nature of using the law in practice (Braye, Preston-Shoot and Wigley 2011), a process that involves interpreting the law and finding meaning with people and situations encountered in practice. The research seeks to uncover how social work AMHPs socially construct the law in practice. A social constructionist ontological position using an interpretivist epistemological approach is therefore well suited to exploring this phenomenon, acknowledging the epistemologically objective and ontologically subjective nature of the law and social work practice.

The rationale for using a qualitative methodology arose from the type of questions that my research sought to explore. Denzin and Lincoln (2011) explain that qualitative research seeks answers to questions that stress how social experience is created and given meaning. Using a qualitative methodology in my research also reflected a commitment to address three

main points, adapted from Denzin and Lincoln (2011: 9): firstly, to capture my participants' point of view by using qualitative interviewing; secondly, to examine the constraints of every day professional life to explore law in practice; and thirdly, to secure rich descriptions of how my participants used the law in action.

4. Choosing approaches to gathering data

The methodological approach involved exploring AMHPs' case stories of how they had used the law in practice during MHA assessments they had undertaken. I employed semi structured qualitative interviewing to elicit these stories and analysed them using thematic framework analysis (Ritchie and Lewis 1994). I also used practitioner diaries (Zimmerman and Wieder, 1977; Alaszewski, 2006). An iterative process influenced choices of the methodology employed. In this section I briefly outline the choices between approaches to data gathering and analysis leading to the final methods used, which involved reaching an acceptable and feasible compromise. Learning about the different approaches that I considered and discounted was influential on the shape of the final research design.

Qualitative Fieldwork

The focus in ethnography of making the familiar strange and the strange familiar appeared to hold the potential to uncover interesting perspectives on the landscape and the use of law in social work practice. The main feature of this approach would have involved studying participants' accounts and actions in every day conditions as opposed to conditions imposed by the researcher (Hammersley and Atkinson 2007). This would have involved participant observation with AMHPs, observing them in their offices and the location of their assessment - the street, a police station, hospital ward or a home - wherever the assessment happened. An overt participant observation would have involved my observations and subsequent perception of how AMHPs use the law in practice.

However, the methodology of ethnography combined with insider-research seemed fraught with practical, micro-political and ethical difficulties, such as ethical implications for including vulnerable service users in research, which ultimately resulted in a decision that ethnography was unfeasible.

Whilst ethnography was not pursued for use in my research, it played a part in the method of qualitative interviews used in my research, which was influenced by reading about ethnographic interviewing that has long been used to shed light on the personal experiences, interpersonal dynamics, and cultural meanings of participants in their social worlds (Heyl 2001).

5. Research strategy

By providing a detailed description of the methodology and methods used in the research project I aim to provide detailed information about the challenges encountered and how I addressed these in the research. I also aim to provide enough information about how the research was conducted to make the significance of my findings to be apparent (Wolcott 2009). Outlined below I provide a description of the research setting and participants, gaining access to the setting, data collection, data analysis, and ethical considerations.

5.1 Research setting and Participants

Research setting

The fieldwork was undertaken with social work AMHPs from three separate local authority areas. Two of the boroughs are inner London boroughs (Borough 1 and 2) and the third is an outer London borough (Borough 3) bordering the two inner London boroughs. The two inner London boroughs also share geographical borders. The fieldwork involved qualitative interviewing and participant diaries. Participants were sampled across three separate areas to include AMHPs from outside the borough where I work and to explore their experiences across different local authority areas. Research interviews were conducted over a period of eight weeks.

With ethics approval from the university in place, and prior to commencing the research, the study gained the required permissions in accordance with the relevant research governance procedures of the three organizations where the research fieldwork was conducted. In my own borough, I approached AMHP social workers outside of my specific team in a separate part of the service so as not to involve anyone within my own team. Outside of my immediate organization I approached AMHP social workers who were not known to me. I sent an introductory email to social work AMHPs inviting them to express an interest in finding out more about participating in the research. Access to AMHPs' emails was provided through intermediary senior managers in the relevant areas, introducing me to potential participants. The email provided full information regarding the study and consent forms were also sent, with the caveat that information about the research and consent would be further formally explained and confirmed prior to interview. Participants were advised at the outset of their right to withdraw at any time without explanation.

The information sheet (Appendix 1) and consent form (Appendix 2) were provided in both paper form and via email to the participants. Those wishing to participate or to seek further information were invited to contact me by phone, email or in person according to their preference. I used a work email address when making email contact and deleted these emails once contact was made. I aimed to recruit 10-15 participants and successfully reached a total of 11. This was a suitable number for my in-depth, qualitative study (Ritchie and Spencer 1994).

Purposeful sampling

My research study sought to answer questions about how social work AMHPs use the law by using qualitative interviews and practitioner diaries as the primary research instrument.

The study used purposeful sampling. According to Patton (1990:169), the 'logic and power of purposeful sampling lies in selecting information-rich cases for

study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling’.

Having selected participants on the basis that they were social work AMHPs in the geographical area where I conducted the research, my final sampling was determined by who responded to volunteer to participate in the research project. In terms of the effect that this method of selection had on my research findings, the participants were mostly experienced AMHPs, both men and women, from a diverse range of different cultural backgrounds. Regarding the trustworthiness of my research, the method of sampling used in is that it was fit for purpose and served the aims of my research project.

Participants

Participants were all social work AMHPs: eight male and four female. All work in densely populated areas of a city in England. Their experience as mental health social workers ranged from five to thirty years, with AMHP practice experience ranging from 6 months to twenty-two years. All participants undertake regular centralized AMHP duties, stepping outside of their individual teams and covering their relevant borough where they receive referrals for MHA assessments at one central location.

Table 2-Research participants

Participant number	Number of years SW qualified	Number of years AMHP qualified	Local Authority	Gender
1	29	18	Area 1	Male
2	17	9	Area 1	Male
3	30	22	Area 1	Male
4	5	2	Area 2	Female
5	17	12	Area 2	Male
6	16	14	Area 2	Male
7	18	12	Area 3	Male
8	16	12	Area 3	Male
9	7	2	Area 3	Female
10	10	8	Area 3	Female
11	8	6 months	Area 3	Male

6. Gaining access

Access to the field was enabled due to my status as an insider-researcher. This status, whilst fraught with implications in terms of my position within the

research (Court and Abbas 2013), may also have helped to gain access to participants as we shared a professional identity (Savvides et al 2014; Morris 2015) as social worker/Approved Mental Health Professional. This may have contributed to participants agreeing to be interviewed, as we shared understanding of the 'prestigious' and 'dirty' aspects of the work (Morris, 2015). As this did not need to be explained by participants in advance of them recounting their use of the law in practice, they were able to focus on their telling of the case as opposed to trying to explain or justify their role.

This may have made a difference because although the use of the Mental Health Act 1983 is a habitual and familiar practice for the participants, it is nevertheless an area where the stakes are high in terms of the implications of AMHP decision-making for the liberty of the person they are assessing. Hence the process of using the law in this area of practice may make participants unwilling to talk to a researcher perceived as being an 'outsider'.

This is also likely to have made a difference in terms of how the case stories were told to me by participants. There was an implied sense of shared understanding during the interviews. Participants conveyed an implied sense of 'you know what it's like' (see Morris 2015) with their non-verbal communication when telling their stories. This was also undoubtedly co-constructed by me in my use of nonverbal minimal encouragers such as nodding my head during the interview, which is likely to have conveyed a sense of 'yes, I know what it is like'.

Ultimately, the co-constructed acknowledgement of shared understanding and being members of the same community of practice was significant in that it enabled access to participants and made a further difference, I would argue, in relation to the ease with which participants were able to focus on the telling of the case during the interview.

Practical considerations such as interviewing participants who work in a geographically separate location within my organization, including participants from two other London boroughs, were put in place not to fabricate 'objectivity'

or to attempt to artificially remove myself from the research but rather as a way of dealing with micro-political issues such as ongoing shared work tensions, albeit acknowledging that these types of considerations have an impact on the shape and substance of the research. Overall, my positionality in the research shifted over the three different settings involving various degrees of insider and outsider position; this resonates with the argument made by Savvides et al (2014) that qualitative researchers operate in a fluid space somewhere between the two positions of insider and outsider. Recognition of my positionality in relation to the research incorporates a reflexive stance; the impact of this on my findings is that my position in relation to participants is critically engaged and transparent.

7. Data collection methods

7.1 Research Instruments

Interviews

I considered case stories as a potentially rich form of data to capture how law is used in practice (Sarat 1990; Shearing and Erikson 1993; Ewick and Sibley 1998; Maynard-Moody and Musheno 2003). These aimed to elicit the taken for granted aspects of using the law in practice, enabling me to get a glimpse of how participants made sense of using the law. Case stories of social work AMHPs using the MHA in practice were elicited from 11 participants. The purpose was to elicit their experiences of carrying out MHA assessments that they had recently undertaken by asking them to talk in-depth about a recent assessment. Interviews were flexibly structured to be able to follow the story.

The use of the interview as a research method has been characterized as a conversation that has structure and purpose (Kvale 2009). The form of interview employed for the research was semi-structured interview; this is an interview with the purpose of obtaining descriptions of the life world of the interview participants, which enables a researcher to interpret the meaning of the phenomena described. My interest in how social work AMHPs use the law in practice required a method that could capture the experience and events of social work AMHPs using the MHA. Therefore, interviews presented a feasible

method of discovering more about the lived world of social work AMHP work and the law. Semi-structured interviews (Appendix 3) offered a flexible yet focused approach (Kvale and Brinkman 2009).

As Kvale and Brinkmann (2009) argue, the type of knowledge gained by interviews is constructed as opposed to being 'out there' waiting to be discovered. This manifested as an issue in my research in relation to finding out the 'truth' about how social work AMHPs use the law; viewing knowledge gained by interviews as 'constructed' as opposed to 'captured' highlighted that truth is an elusive concept and that the interview outcomes involved my interpretation and constructions of the meanings of participants' experiences of using the law.

Working with stories

Story-based socio-legal research influenced me to work with case stories (Sarat 1990; Erikson and Shearing 1991; Sibley 2005; Musheno and Maynard-Moody 2003; Braye, Preston-Shoot, and Wigley 2011) as a way of potentially revealing the tacit knowledge and norms of social work AMHPs. This puzzle resonates with Braye et al's (2011) argument that 'getting to the heart of what happens in social work decision-making is a methodological challenge' (Braye, Preston-Shoot, and Wigley 2011: 77). I considered using case vignettes when designing the study. An advantage of using this approach is that I would have been able to design scenarios focusing on a specific area of mental health law and practice that I wanted participants to talk about (Braye, Preston-Shoot, and Wigley 2011; O'Hare et al 2013). This holds the potential to find out about the attitudes and views of practitioners on sensitive subjects, such as the use of coercive laws, where research participants may perceive the vignette as separated from their own practice (O'Hare et al 2013).

However, participants would not have access to all the information that they would use in practice and the contents of the vignette may not always reflect the reality of practice (Braye, Preston-Shoot, and Wigley 2011; O'Hare et al 2013). I chose participants' own case stories in preference to vignettes because doing so seemed more suitable for the question I sought to explore.

The emphasis here was on the relationship between law and practice, therefore I needed a method that got close to practice; case stories offered the potential to explore how social work AMHPs use the law in the complex terrain of practice where they are not solely in control of the facts and how situations are defined and tackled (Braye, Preston-Shoot, and Wigley 2011). My interest and focus is on the entire process of how participants use the law; case stories are a vehicle for participants to retrace their steps and talk about how things unfolded - 'the speculations and the implicit knowledge, the influence of time and evolving scenarios on interpretation and judgement' (Braye, Preston-Shoot, and Wigley 2011: 77).

My argument is not that case stories are better or worse than case vignettes, rather that case stories worked better for my own research question, taking account of the feasibility and possibilities of potential research approaches. For example, empirical research on the relationship between law and social work has moved beyond the use of either vignettes or researcher-led interviews by using peer interviews about complex events where participants discussed case work with peers (Braye, Preston-Shoot, and Wigley 2011). I considered using this approach, but it posed additional challenges in logistics and organisation that appeared daunting and too risky at the time.

The research approach I used has its own set of limitations; case stories invite reflection on a piece of work where the desire to avoid discomfort may invite rationalization, where things are tidied up in the telling of the story (Braye, Preston-Shoot, and Wigley 2011). However, my position as an insider may have enhanced the utility of this approach in my own study. Braye, Preston-Shoot, and Wigley(2011) have argued that presenting actual performance and thought directly to researchers may be affected by the level of trust that can be built, the prompts that are used, and whether participants perceive the interview as a kind of test.

I view the stories elicited during the interview as a useful method of getting at the taken for granted world of practice described by participants, providing a window into their world (Sarat 1990; Erikson and Shearing 1991; Sibley 2005;

Musheno and Maynard-Moody 2003), which is then analysed using thematic analysis.

The semi-structured interviews elicited stories by encouraging participants to tell a story about a recent MHA assessment that they had undertaken. The use of story encouraged participants to provide a rich description of events as they unfolded over time during the actual assessment - a process that usually spanned several hours.

The stories told began with an account of a referral that had been received and unfolded as an account of action over the course of time, culminating in the outcome of the assessment. They were a useful way of understanding how participants made sense of the action unfolding in front of them and in that way served as a valuable device to glimpse the dynamic and temporal nature of the law in practice and the social processes surrounding it. Stories enabled participants to describe what happened from their vantage point in a way that linear interview questions could not have provided (Mishler 1991). What I have gathered are stories of the MHA in practice. Interviews were recorded on an MP3 voice recorder and transcribed strictly verbatim. I took field notes immediately after each interview where my initial thoughts and observations about the interview were recorded. These notes were used to further illuminate the data analysis.

7.2 Accounting for the difference between what people do and what people say that they do.

In highlighting above my attempts to address the difficulty of accessing experience as 'lived' rather than as 'recalled', it is pertinent to note the inherent limitations of interviews in relation to the disjunction between what people say they do and what they do (Maynard-Moody and Musheno 2003). The use of practitioner diaries (detailed below) to record participants' impressions of the experience right after the event is a possible way to minimise this.

I acknowledge that there are limits to the representation of experience.

Reissman (1993) reflects on the limits of representation by asserting that ‘all forms of representation of experience are limited portraits’ reminding us that we are ‘interpreting and creating texts at every juncture’ Reissman (1993:15) and that ‘our narratives of others’ narratives are our worldly creations’ (1993:15). Therefore, it is important to recognise that I have collected talk and created text that ‘represent reality partially, selectively, and imperfectly’ Reissman (1993:15).

7.3 Practitioner Diaries

I attempted to use practitioner diaries to capture the experience of undertaking a Mental Health Act assessment by asking participants to make diary entries following an assessment, outlining their feelings and impressions with the aim of capturing contemporaneous experience. My rationale was that this method had the potential to provide insight into how individuals interpret situations and ascribe meanings to actions and events (Alaszewski 2006).

I used a solicited diary, providing participants with a diary template (Appendix 4), which was intentionally open-ended and not overly structured following Alaszewski (2006), who advises seeking to minimize the intrusion of the diary by creating formats that are open in structure and informal. Despite their potential, diaries are not widely used as a method in research. Willig (2008) suggests that this is because the method constitutes a challenge for both parties. The challenge for participants is being asked to maintain a commitment to maintain a record over a period, which ultimately is handed over to the researcher. The researcher faces the challenge of recruiting participants who are willing to commit to keeping and recording in the diary. I therefore avoided providing detailed prescriptive instructions that might restrict participants’ freedom of expression.

Participants were introduced to the diary and provided with a template during the in-depth interview. This was an adaptation of the *Diary-Interview method* (Zimmerman and Wider 1977), where the diary is the focus of data collection and interviews provide a structure for the diary research. My interviews had

their own structure and operated independently from the diary.

In fact, most participants did not fill in the diary, perhaps viewing it as unnecessary having provided an in-depth interview. However, I would argue that the challenges posed by the diaries did not detract from the potential strengths of the in-depth interviews that were conducted. Despite the limitations of the diary, I gained a significant amount of learning about this method in terms of reflecting on how I could utilize it more effectively in the future. While recognising that here it didn't work out as well as I hoped, I learnt from it and consider that as an adjunct method of data collection in the overall design of the research project the way that it worked out does not adversely impact on my findings as they are not dependent on the diary method.

I reflected on the diary experience by reading more widely on the method and by presenting to peers and academic attendees at doctoral weekend workshops where I outlined the challenges that I experienced. Perhaps the most valuable lessons learnt were twofold: firstly, the diary must form a central plank of the research as opposed to an adjunct role, and secondly ongoing relationships with participants are key to enabling the success of a diary as a method of data collection. Giving the diary template to participants at the interview militated against its completion. I had originally intended to go back for a second interview based on the diary; however, this proved a logistical challenge as pressure of work on participants did not allow further space for another interview within the research timescales. An alternative course of action would have been to provide participants with the template in advance asking them to record their thoughts about the assessment that they were going to talk about in the interview. If I use this method in the future I will address these valuable lessons and would in addition provide a voice or video recorder for participants as opposed to asking for the diary to be written and would re-visit participants over an extended period to encourage participation.

8. Data analysis

The method of data analysis used for the study was 'framework' analysis.

Ritchie and Spencer (1994) developed the framework approach to qualitative data analysis for applied policy research, and as such this resonated with the focus of my research question on the use of the Mental Health Act 1983 in practice.

Srivastava & Thomson (2009) outline the key features of the framework analysis approach: it is based in, and driven by, the original accounts and observations of the people it is about; it is dynamic and open to change, addition and amendment throughout the analytical process; it is systematic allowing methodological treatment of all similar units of analysis; it is comprehensive allowing a full rather than partial or selective review of the material collected; it enables easy retrieval allowing access to, and retrieval of, the original textual material; it allows within-case and between-case analysis enabling comparisons between, and associations within, cases to be made; and finally it is accessible to others - the analytical process and interpretations derived from it can be viewed and judged by people other than the primary analyst.

Computer-assisted qualitative data analysis in the form of NVIVO was utilized to manage the data (Ritchie and Spencer 1994). At an initial phase in the data analysis of identifying initial themes and a later phase when it came to defining themes, pen and paper were used alongside Nvivo to help me connect with and get a feel for the data, and to enable me to view it from 'above'.

Stage 1-Recording and transcribing interviews

The interviews were recorded on an mp3 recorder and transcribed strictly verbatim.

Stage 2-Familiarization

The transcripts were examined and re-examined to enable familiarization with the interview data, with the aim of enabling me to understand the diversity of circumstances and characteristics within the data set. Ritchie and Lewis (2011) characterize this stage as analogous to conceptual scaffolding; the process of familiarization is akin to building the foundation of the structure. I was mindful

that the journey of data analysis was promising to be dense and time-consuming; I therefore attempted to be as systematic and methodical as possible during this phase to enable the analysis of my data to be built on a strong a foundation as possible.

As part of the familiarization process I reviewed my research proposal and aims and re-examined the sampling and profile of participants.

Building a thematic framework

Stage 3-Identifying initial concepts

A thorough review of both the range and depth of my interview data (Ritchie and Lewis (2011)) was then undertaken; this involved making a list in pen and paper of what appeared to be important concept categories within the transcriptions of the interviews.

Stage 4-Constructing an index

Having generated an initial list, I turned to constructing a manageable index. The function of an index at this stage is to ensure that there is clarity in relation to the concepts within the framework to guard against areas of overlap. To achieve this involved three discrete phases: i) identifying links between categories on the list, ii) grouping them thematically and iii) sorting them according to different levels of generality. This resulted in an index that had a hierarchy of main and sub classifications. In each sub-set in the index there was an 'other' category. The purpose of this (Ritchie and Spencer (1994)) was to provide an identifier for any issues not otherwise captured the sub-categories.

Stage 5- Labelling/tagging the data; refining the index

The index was then applied to the raw data of the interview transcripts using Nvivo. This involved reading each phrase of the transcripts in detail and determining which part of the index applied to it, marking the reference to the corresponding part of the index. Using Nvivo enabled the individual passage of the tagged transcript to be placed with the corresponding index label. Applying an index in this way enabled me to show which concept or category is being

mentioned within a part of the interview transcript. This process was applied systematically across the entire data set.

Ritchie and Lewis (2011) acknowledge that the preliminary index will be likely to require refinement at this stage, following initial application. I used doctoral supervision to assist in refining the index, and found this a helpful source of feedback that enabled me to critically appraise the initial index and discover overlapping categories that could be collapsed and further categories that could be subdivided.

Thematic charts

Stage 6-Sorting and synthesizing the data by creating thematic charts

The next step involved ordering the data so that material with similar properties was located together to develop a thematic structure. Each main category and associated sub classifications were plotted on a separate thematic chart. Within each individual chart each participant in the research was allocated a row in the matrix while each sub topic was displayed in a separate column. Each column was assigned a separate number to enable easy referencing between columns. In total seven thematic charts were created covering 57 sub-topics.

Thematic charting

This part of the process was challenging and I was initially reluctant to summarize too far, as I was concerned that if I did so I would lose the voice of my participants. Ritchie and Lewis (2011) explain that the key question at this point is to ask, 'how do I summarize the content to best retain the context and voice of the respondent?' and that answering this question effectively requires fine-tuned judgment about the content of material to chart. The task of synthesizing – summarizing without losing content or context - involved finding a balance between having over-condensed data that lacked context and including too much data so that I was 'bogged down'. An important learning point that helped me in this process was to conceive of the synthesizing of my data as enabling me to have a 'viewing platform' from which to see it (Ritchie and Lewis 2003).

Stage 7-Searching for themes

The next stage in the analysis involved defining elements and dimensions, refining categories and classifying data that were now contained on each separate chart with the aim of finding themes. Framework analysis involved using the framework grid to identify themes, I used a mind map help me to identify the themes from the grid. The approach of using a mind map was influenced by Braun and Clarke (2006) who recommend this approach to visualise themes. I was inspired by the approach of drawing a mind map to help to visualise themes that were identified in the framework. This idea for a mind map came from Braun and Clarke (2006), but did not involve any switch between thematic and framework analysis.

An important learning point for me at this stage of the research was in relation to the conceptualisation of themes 'residing' in the data. I had initially misinterpreted this as meaning that themes were 'residing' in the data waiting to jump out at me. However, the use of a mind map was useful in helping me to re-conceptualise the notion of themes, emphasising that 'if themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them' (Ely, Vinz, Downing, & Anzul, 1997: 205-6 in Braun and Clarke 2006).

9. Ethical considerations

Ethical review process

The ethical review process required an ethical review application to be made to the University of Sussex. The application was successful and a certificate of approval was granted on June 13th, 2014, reference number: ER/SA455/1 (Appendix 5). Research governance requirements were followed in the authorities where interviews took place.

The main learning point for me was the importance on engaging critically with the ethical issues impacting at each stage of the research project as opposed to taking a 'getting through it' approach. Ethical issues were clearly at the fore

as the research involved talking about vulnerable people who were being assessed under the Mental Health Act 1983 where their liberty had been at stake, and in a practice context where it has been questioned as to whether it can ever be 'ethical' to admit someone under the Mental Health Act 1983 (Kinney 2009; Maylea 2017).

Kvale and Brinkman (2009) highlight Aristotle's virtue ethics as a compass to guide the social researcher along the path of qualitative research, with its terrain inherently occupied with dynamically manifesting ethical issues.

Informed consent and confidentiality

Informed consent was sought from all the interviewees. Participants were invited to volunteer for an interview with me. They were provided with full information regarding the study and consent was formally explained and obtained prior to interview. Participants were advised at the outset of their right to withdraw at any time without explanation. Confidentiality in terms of the content of interviews involved a 'limited confidentiality' undertaking, to allow for the fact that I might have to report something that appeared to me to place a third party at risk (Appendix 1).

The semi-structured interviews were transcribed with all names of people and organisations omitted. The interview recordings were then deleted from the recording device. The transcripts and the practitioner diaries were stored on a password-protected computer with no identifying information attached to them.

A unique identifier was used for each participant, which gave no indication of their identity and was used in all handling of the data and presentation of findings. The link between the participant's name and the unique identifier is known only to myself and was not documented in writing. No individual names, place names or names of organisations were identified in any data handling or presentation of findings. Organisations were described in a generic manner omitting any characteristics that may reveal the identity of that organisation.

The research has been reported in such a way to ensure as far as possible that the participants and any other person or organisation cannot be identified.

Significant learning about research ethics was gained over the course of my doctoral studies and research. My first experience of ethical review occurred in the early phase of the doctorate where I undertook a pilot study in my organization that involved interviewing a small number of AMHPs. At this stage I viewed the ethical review application as something to get through to enable me to get on with my research. My first application was returned to me with several queries and proposals. The second application was successful following amendments to the application. The learning gained from this process was the importance of active engagement with the process of ethical review where transparency and careful consideration of the ethical issues enhanced the chances of gaining approval, as opposed to militating against it. I applied this learning to the ethics application for my research study, which was approved at first attempt.

My learning about ethical review also involved a realization that ethical considerations do not end at the stage of approval by a research ethics committee. Wiles (2013) acknowledges this point in her argument that enhancing 'ethical literacy' is not solely about learning how to achieve ethical approval; it also involves researchers engaging with ethical issues as they emerge throughout the entire process of research.

10. Conclusion

This chapter has provided a critical reflection on the methodology and methods of the research. The ontological stance taken draws on social constructionism, with an interpretivist epistemology. I have critically engaged with my position in the research, acknowledging that I am personally implicated at every level, at times occupying a fluid position across the insider-outsider researcher paradigm. Data collection involved in-depth semi-structured qualitative interviews that elicited case stories about recent MHA assessments. These

were combined with practitioner diaries. Social work AMHPs from three different local authority areas participated in the research.

The methodology and methods enabled my research to capture and interpret the socio-relational process of using the law in practice by interpreting the meaning of case stories that captured the entire process of using the law in relation to real-life MHA assessments from their beginning to conclusion. In providing a transparent account of the methodology I have been transparent about the strengths and weaknesses of the design and execution; overall I have confidence that the study was fit for purpose.

Chapter 5: Findings

1. Introduction

In this chapter I discuss the research findings that emerged from my analysis of the case stories about AMHPs' involvement in Mental Health Act (hereafter MHA) assessments. These are organised thematically under five themes: 'understanding the referral situation'; 'understanding the individual'; 'understanding the situation causing concern'; 'community versus containment'; 'relationships and resources'.

These themes, whilst presented in a linear format on paper, are messy and iterative in practice, where there is overlap and dialogue between themes. The themes illuminate that a key feature of AMHP participants' use of law involves a socio-relational endeavour, interacting with others to find meaning about individuals and situations causing concern. They reveal that participants search for an understanding of the referral situation where using the law involves a process of understanding the individual at a point of rupture in their lives when their behaviour causes problems and concern to other people, who were usually living in close-proximity to the person assessed. Troubles and problems dominated the discourse of understanding the referral situation, where the endeavour to find meaning drew on the views of family members and professionals alongside the AMHPs' own interpretation of these issues. Risks and concerns were formulated through a preoccupation with the impact of risk on the community, where feasibility of the person not being detained is brought into question. Table 3 below provides an outline of the themes together with the key points dealt with under each theme.

Table 3-Themes

Theme	Key points dealt with under theme
Understanding the referral situation	Temporal and relational perspectives An adversarial atmosphere (legal wind-chill factor) Troubles emerging as problems Conjuring notions of risk The nature of these risks Feasibility of <i>not</i> being in hospital A rupture in the relationship between services and person referred Organisational factors (legal wind-chill factor)
Understanding the individual	Relational understandings Combining background information with face to face impressions Mediator role of the AMHP Influential role of social and family situation Interpreting troubles and problems Contradictions in understanding
Understanding the situation causing concern	Perspectives of risk on the community Views of family or carer on what needs to be done Risks to family and others Risk to health and safety
Community versus Containment	Feasibility to be in the community Hospital as a place for plans to be put in place Trust Medication in the community Ability of family to cope Feasibility and Availability-Community support options
Relationships and Resources	Autonomy as an AMHP Inter-professional working relationships Inter-agency working relationships

2. Theme 1: Understanding the referral situation

This theme deals with how participants describe the process of understanding and meaning-making when receiving the referral, which was normally received from another professional. This theme relates to the early stages of receiving the referral where the stage is set for the forthcoming assessment. All participants commenced their case stories by talking about the MHA

assessment referral, which encompassed accounts of trouble and problems, and how these were interpreted by family and professionals who encountered the person before the AMHP became involved. Within this theme, risks were threaded into the perspective of AMHP participants at the referral stage; organizational factors were an influential component of the theme in terms of how participants described using the law to interpret the referral situation.

Section 13 (1) Mental Health Act 1983 (as amended) (hereafter MHA), provides that where a local social services authority has reason to believe that an application may need to be made to hospital in relation to a person in their area, then there is a duty to make arrangements for an AMHP to consider the case on their behalf. If the AMHP is satisfied that such an application ought to be made in respect of the person referred, and of the opinion, having regard to any wishes expressed by relatives or any other relevant circumstances, that it is necessary or proper for the application to be made, there is then a duty incumbent on the AMHP to make an application.

Receiving the referral requires the AMHP to interpret the current concerns about the person referred; this runs alongside the AMHP encountering the complexity of the referral situation and challenges. All the participants interviewed recounted that receiving the referral was accompanied by something serious in the recent past that framed the current concern about the person. The person assessed was described by AMHPs regarding this, for example the AMHP who assessed a woman in hospital who had jumped out of a moving car as her family drove her to A&E. This event that occurred in the recent past was used as a bearing on the future where the likelihood of her doing the same thing again was an important consideration. Another example was an AMHP who recounted that the person she assessed had, in the recent past, tied a belt around her neck attempting to hang herself. This event in the recent past was again the current issue of concern and used as a bearing to consider the potential risk of harm occurring in the future, where stopping her from hanging herself again was the main concern. Interestingly, one AMHP who, in contrast to most participants, described the referral as difficult to unpick, related this difficulty to an absence of previous history with this person in

terms of their contact with mental health services; the implication here is that there was no written record of the person's history that could be a source of information for the AMHP about the history of the person. Referring to such a difficulty, they explained:

'Whereas this, when the referral came through it was difficult to kind of pick through, you know, what the major issues were in this one because it wasn't, she had no kind of previous history, contact with the mental health services.' (Participant 11).

Temporality is then an important phenomenon in terms of how the AMHP calibrates the past, both as told to the AMHP and as discovered by them through future imaginings of the potential for risk and harm. This quote above is suggestive of the importance of temporality in using the law to navigate the referral, the AMHP appearing to find it more difficult to unpick and orientate because of a lack of history. This also suggests that if the history was written down, it would have aided their orientation to the referral situation. Temporality and time are thus important concepts in terms of how the AMHP participants described the experience and meaning of using the law to navigate receiving the referral.

An adversarial atmosphere accompanied the referral for a MHA assessment. By this I mean that there was an element of opposition involved in the account of the circumstances of the person referred. The AMHP became aware of the individual at a point of crisis in that person's life when their behaviour or beliefs gave rise to concern when noticed by others. Family members were also often key players in terms of their proximity to the person referred and their experience of the behaviour causing concern. Other health professionals had often had contact with the person before the AMHP became involved and were likely to be the instigators of the MHA assessment referral. The referring professional had already formed a view that assessment and or treatment in hospital was necessary. In this sense, the referral was in most cases instrumental to a desired outcome. Opposition was evident in relation to the

person assessed, where other people, usually family members and professionals, were opposed to their unusual behaviour and or beliefs, and to their non-engagement with mental health services and treatment. Professionals were in opposition to the person being in the community without succumbing to contact with mental health services. There was opposition from the person assessed, usually this was an opposition to treatment and contact with mental health services. The adversarial atmosphere was reminiscent of Goffman's pre-patient phase (Goffman 1961) where he refers to the allegiance between family and professionals involved in arranging the admission to hospital as a coalition that works as a 'betrayal funnel' to receive the person into the in-patient phase.

However, unlike Goffman's betrayal funnel, the opposition was not always formed in unison between family and professionals against the person assessed. It also occurred between professionals where opposition to what the assessors considered the right thing to do, in contrast to the views of other professionals, was highlighted. The quote below from an AMHP (Participant 5) reveals that he was using the law to do what he considered the 'right thing' for a person he assessed. From his perspective, this was to enable her to be admitted to a medical ward where her medical problems could also be addressed alongside her mental health needs; the AMHP described his aims as making sure the person received treatment and care in a suitable environment, which both he and the independent doctor thought was a general medical ward. This was in stark contrast to the view of the medical consultant and nursing staff on the ward of the general hospital. The AMHP describes overt opposition from the general hospital to the person being on the medical ward, involving both tension and opposition. This explains why this participant describes taking a doctor with him as the independent doctor who "didn't mind being a bit bolshie". The AMHP describes trying to promote the rights and needs of the person assessed where they were considered awkward and difficult to relate to by staff on the medical ward. The doctor making the first medical recommendation had formed an alliance with the views of the medical ward, and the AMHP and independent doctor were opposed to what they saw as an inappropriate admission to this type of ward because they thought it was not suitable for the person assessed. The person assessed was a retired professional whom the AMHP and independent

doctor connected with and wanted to stand their ground for. The sense portrayed by the AMHP in describing the case story was that he wanted to promote the person's dignity.

The quote below from the AMHP in question reveals that the assessment was approached with an adversarial atmosphere between different professionals:

'I remember going to assess a retired person at the general hospital. The referral came from the Psyche Liaison Team. She had just attempted suicide. She had significant physical health issues that left her in substantial pain and she didn't want to live anymore. They were finding it very difficult to work with her on the ward and so they wanted to put her on a section. I particularly chose a Section 12 doctor that I know who would be very appropriate with an older person and doesn't mind being a bit bolshie. I had the first medical rec already done by the Psyche Liaison'. (Participant 5).

For most of the AMHPs however, the adversarial atmosphere was experienced because of opposition between the behaviour and beliefs of the person assessed, which were considered unusual, and those of family members who struggled to cope with them. Professionals struggled to be able to respond other than by requesting a MHA assessment, usually because of a lack of meaningful dialogue with the person, based on difficulty achieving this in the context of the person showing signs of acute mental distress. Added to this, the person was usually referred because they opposed other less restrictive alternatives offered.

The quote below is part of an AMHP's description of such opposition where family could no longer cope with the behaviour and beliefs of the person because of the impact on family life. A community mental health team had been working with the person but was now opposing their continuation at home because they believed that the person's mental state was deteriorating.

Opposition occurred here because the person assessed held very contrary views about what they considered best and crucially were opposed to being admitted to hospital. This opposition occurred in the context of experiencing mental distress:

‘Things appeared to come to a head in the last three months when he was beginning to think that if he had any contact with a woman, there was a possibility that he was going to turn into a woman. That in itself sounded more like psychotic phenomena. However, there were other bits to his presentation which meant that even though he was not presenting with significant self-neglect, he was not but he was not allowing his family to support him in some aspect of his personal hygiene’. (Participant 8).

The quote speaks to a further adversarial atmosphere characterised by opposition between the person assessed and his family where his self-care was deteriorating in the context that he needed support from a family member to look after his hygiene but was now opposing this, to the point where the family were now frightened to offer the support for fear of these offers being met with aggression. The context here is that the person had assaulted a family member while opposing offers of help.

The adversarial atmosphere, as outlined above, that accompanied referrals for a MHA assessment represented a component of what is referred to as the legal wind-chill factor in the theoretical framework at chapter 4 under legal consciousness theory, and referred to later in the discussion at chapter 6. The atmosphere described is understood as representing the legal wind chill-factor, that the adversarial atmosphere of opposition experienced by participants is relevant in how they relate to the law.

AMHPs described the referral in terms of an account of troubles accompanied by an emerging interpretation of problems linked to the person’s mental health

and a sense that 'something needs to be done' to address the risks that are brought into view. The 'something needs to be done' was co-constructed with the referrer and during the MHA assessment was further interpreted by the AMHP formulating shared understandings with others, normally family members. In community referrals recounted by participants, a professional had done some work in the space between noticing the trouble and understanding it as a problem that involved the possibility of the person needing to be in hospital. However, this is not always the case and the noticing of the trouble was sometimes formulated as a problem that required a referral to an AMHP without further extrapolation or trying alternative interventions. The trouble that was formulated as a problem requiring a referral to an AMHP was clearly exemplified in the description of an AMHP about assessment that took place in A&E, where the person had been brought in by a family member. The AMHP received the referral from a liaison psychiatry team based at the A&E department, who had assessed that the person had attempted suicide and remained suicidal and was not expressing any remorse about the suicide attempt, and were unable to guarantee her safety. The crucial context here is that this person had refused the offer made by the liaison psychiatry team for voluntary admission to hospital. These factors were indicative of the trouble being formulated as a problem requiring referral to an AMHP. However, this was in contrast with other participants who described undertaking MHA assessments in the community where some longer-term work had gone into the space between noticing the trouble and understanding it as a problem requiring referral to an AMHP. An example of this is seen in the account provided by an AMHP who described how the community team had put in place a community support worker to support the person to be able to leave the house and address their social isolation; this gradually became unfeasible because the person became more pre-occupied with rituals, which eventually prevented the person from leaving the house at all, thus the community mental health team considered that this was now a problem that required referral to an AMHP. In some of the case stories recounted, the noticing of trouble that required a referral to an AMHP occurred in the context of the community mental health team being aware of a problem in relation to a person disengaging from contact with mental health services, and in the process stopping their treatment for

mental disorder. One such case is exemplified by the entire case story of Participant 9 (see appendix 7) where the AMHP sets the scene by describing that the mental health team had lost contact with the person; she highlighted that she sees this a lot where teams lose track of someone who has disengaged from contact and treatment. The AMHP describes that by the time the team had made contact and seen the person the only response considered available was a referral to an AMHP.

In all the MHA assessments recounted by AMHPs, the end outcome was detention under section 2 or section 3 MHA. The referrals all conjured notions of risk where the feasibility of the status quo continuing was called into question by others, often in stark contrast to the views of the person assessed. The perception of risk was ever-present for the AMHP, as was consideration of where that risk should be situated. There was a desire for the risk to be contained, although there was a difference in response to perception of risk to self in comparison with risk to others, as outlined below. These risks were not abstract or far removed. An event had occurred involving actual or very likely harm and was serious enough to merit consideration for compulsory admission to hospital.

The feasibility of the person *not* being in hospital as a response to contain the risk was the focus. Table 4 below shows the nature of the risks that confronted AMHPs.

Table 4 – The nature of risks confronting AMHPs

The nature of risks confronting AMHPs
Two attempted hangings
A person running on a live train line believing (apparently falsely) that security services were pursuing them
A person who had jumped out of a moving car
A physical assault on family members
Serious self-neglect involving loss of a limb
Threatening to harm others in the context of acute psychosis
The individual tasered by police in the context of making threats whilst armed with a knife.

The participants' focus outlined above is illustrated in the following quote from Participant 4 below, which described the risks to the person and other people in the context that the person had already absconded from hospital (whilst detained under section 2 MHA) prior to being assessed by the AMHP under the MHA and on this occasion had physically assaulted a family member. The AMHP described the feasibility of the person *not* being in hospital by suggesting that had the person not been detained then within a week there would be an event where someone would be hurt or the person would end up back in hospital. This is achieved by recalling recent events from the past to emphasise the high level of risk in question:

'Walking on train tracks and then once he absconded attacking his family was another. Had he been discharged that day, within the week there would be an event that would either end up with someone being hurt or him being brought back into hospital'. (Participant 4).

The focus on the feasibility of the person *not* being in hospital is also demonstrated in the following quote from Participant 9 in the entire case story (below) where the AMHP described completing the application for admission to hospital under the provisions of section 2 MHA. The participants discussed the feasibility of the person *not* being in hospital to contain the risks, highlighting that the person's quality of life was currently compromised because of his disturbed mental state and that there was risk to his family and to himself because he was not eating adequately:

'And then I, um, felt that his quality of life is not one that he would normally be living. If he was well, he wouldn't be living like this, um, and for some reason he's declined and I, and I agreed that I think that he needed to, there was a risk to his family. He was not eating, he was not looking after himself, so there

was a risk to family and his health and safety, so I completed my application'. (Participant 9).

The feasibility of the person *not* being detained to contain the risks is further illustrated in the quote below from an AMHP describing an assessment where the person was already in hospital; the feasibility of alternatives other than to detain the person is weighed up regarding the resources available in the community. The most intensive of these resources was the Home Treatment Team; however, the resilience of this team in containing the risks was called into question by the AMHP, with the implication that the answer was that they could *not* manage this person. Thus, the case for the feasibility of the person not being detained is made out:

'But I suppose it's about looking at what the resources are like in the community if that person were to be discharged. Would the home treatment team be able to sufficiently manage the care and keep the risks to a minimum while that person was getting better?'. (Participant 2).

The relationship between mental health services and the person referred for a MHA assessment was highlighted by participants; often this was described as a rupture in the support provided to the person by community mental health services, with a focus on lack of consistency of pharmacological treatment and the notion of obstacles encountered in working with the person.

The following two quotes are illustrative of the rupture and focus on inconsistent pharmacological treatment. In the first of these (Participant 7), the link between an absence of medication and bizarre behaviour is emphasised; in the second (Participant 8), the absence of medication is linked to the person remaining out of hospital for six years, although this is also linked to current concern from family members:

‘So really for a few months he has not been collecting his prescription. He gradually started disengaging from the service and when mother, he lives at home with, his aged mum, was suddenly expressing concerns about his behaviour being bizarre. He’s also allegedly stopped taking his physical health medication’. (Participant 7).

‘Before the assessment, one thing that stands out is the fact that this gentleman, though history of non-compliance and history of admission in hospital. He hasn’t been in hospital for well over I think six years or so. So, I initially questioned the fact that probably the care coordinator should have been more proactive but they told me about the efforts they’ve been making and mum is getting really concerned’. (Participant 8).

This ties back to the theme of understanding the referral situation, highlighting that an adversarial atmosphere is characterised as such by the person opposing contact with mental health services and treatment. The second quote above by Participant 8 also reinforces the emphasis on the importance of temporality and time.

Further elements of the legal wind chill factor, described above, encountered by participants involved systems and organisational factors that highlight a difficult terrain of practice where the work is complex and often fast paced. Time was a significant factor as a back drop of additional pressure, where finding out about family and locating the Nearest Relative² were priorities that were often made more challenging by issues such as poor timing of referrals and the AMHP experiencing distractions. All the AMHPs completed the MHA

² The AMHP has a duty to consult with a Nearest Relative, defined by section 26 Mental Health Act 1983 (as amended).

assessment on the same day as they commenced, except for one who used twelve days to make an application, having received two medical recommendations on the first day of the assessment.

Pressures were intense:

'I'm overwhelmed actually because I do so many assessments!'. (Participant 5).

'My last day on AMHP duty was a really quite an intense one with four assessments. Some of those assessments, particularly towards the end of the day, were probably a bit more haphazard than others, and they're the more memorable ones as a result.' (Participant 4).

On the whole participants described a deficit in organizational planning of referrals made to them, most often attributed to assessments in hospital for section 3 MHA when the person was already subject to section 2 MHA. This is a further component that is characterized by the legal wind-chill factor outlined in the theoretical framework at chapter 3 and the discussion at chapter 6. They highlighted that these assessments were referred at the last minute, thereby placing the AMHP in a position where they described feeling up against the clock in relation to a section 2 expiring. Participants described a clear tension between adhering to timescales, on the one hand, and on the other the legality and legitimacy of consulting and undertaking the assessment in a way that adheres to the promotion of the person's rights, such as consultation with their nearest relative. The AMHP participants described anchoring themselves to the statutory requirements to buffer against or rebutt organizational challenges, for example not feeling the need to compromise or cut corners in consulting with a nearest relative when a section 2 was about to expire, despite the pressure they experienced because of referrals that were poorly timed.

Three examples illustrate the poor timing of referrals to AMHP participants:

'a guy who had been on a Section 2, who was in one of the acute wards. Who, who can say; only the nursing team thought they'd referred him the previous week for assessment but they clearly hadn't'. (Participant 2).

'They had a single recommendation which had in fact expired, and the Section 2 had expired or was about to expire at midnight on the day he was referred, and obviously with issues around consultation, it was one that we couldn't do at that point'. (Participant 3).

'The Section 2 was about to expire. This is an on-going issue. The Section 2 was about to expire and for whatever reason the ward staff hadn't allowed enough time for us to consult, arrange things and get over to a faraway place in this instance.'
(Participant 1).

In the context of the organisational challenges experienced by participants when understanding the referral situation, ascertaining the family composition was a priority at the point of referral, with an orientation towards finding out about the nearest relative. This would be a priority even in the absence of the organisational challenges; however, the challenges such as those recounted above in the quote by Participant 3 and 1 highlight that the legal requirement to consult with and inform the nearest relative under section 11 MHA is addressed by the AMHP in an atmosphere of pressure that occurs because of the organisational factors. The quote from Participant 3 provides further evidence of AMHPs anchoring themselves to the statutory criteria to weather the organisational challenges. The quote demonstrates that the AMHP is concerned with doing things right in terms of what he considers to be using the law in the right way, in this case within the provision of s11 MHA; the priority for the AMHP (Participant 3) was to use the law in accordance with the

requirements as opposed to buckling under the organisational pressure to side step or take short cuts with the consultation and informing of the nearest relative. The context of this participants saying that 'with issues around consultation it was an assessment that could not be done at that point' illustrates that the assessment was not undertaken in a hurry just because the section 2 was expiring; the assessment was not undertaken until it could be done in accordance with the requirements to consult with family. Often family members are implicated in the referral story of trouble and the feasibility of continuing to cope, with their proximity to the person referred emphasised. The AMHPs viewed the family as important in terms of finding out about their view of the situation, finding out about the support they could feasibly provide and understanding the impact on them.

At this point of the MHA assessment the action is structured by the requirements for the AMHP to identify, inform and consult the nearest relative. Section 11 (3) MHA provides that within a reasonable time after the application for the admission of a person for assessment under s2 MHA is made by an AMHP, that professional shall take steps as are practicable to inform the person (if any) appearing to the nearest relative of the person that the application is to be or has been made and of the power of the nearest relative under s23(2)(a) MHA. In the case of admission for treatment (s3 MHA) the AMHP may not make an application in the following circumstances: if the nearest relative objects to the application being made (s13 (4) (a) MHA) or the AMHP has not consulted the nearest relative, however this requirement to consult the nearest relative in the case of an application for s3 MHA does not apply is in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay (s13 (4) (b)).

AMHP participants described inquiring more deeply into the troubles by searching for an understanding of the individual. This involves inter-relational understandings, discussed in the next theme.

3. Theme 2: Understanding the individual

This theme deals with how participants describe participating in the process of understanding and meaning-making about the individual person referred to them. This theme relates to how participants described gaining information about the person assessed from different sources, including from the actual person assessed under the MHA. I now provide an overview of the theme of understanding the individual. The points addressed here are the AMHPs' inter-relational understandings of the individual combining collateral views and individual impressions, the difference in the approach to using the law where risks are predominantly to self as opposed to others, and the interview as a site where the law is used on a tightrope between coercion and collaboration. The temporal experience of using the law in practice will be outlined, highlighting the significance of the past in terms of the history of the person assessed, the present in terms of the demeanour of the person and their unusual beliefs or behaviour, and the future in terms of the impact of the mental disorder and implications of risks.

The legal grounds for an application under the MHA are implicated at this stage of the MHA assessment. An application under both section 2 and section 3 MHA is founded on the written recommendations of two registered medical practitioners. In the case of section 2 MHA an AMHP may make an application for admission in respect of the person assessed on grounds that the person is suffering from a mental disorder of a nature or degree which warrants the detention of that person in a hospital for assessment (or for assessment followed by medical treatment) and the person ought to be detained in the interests of their own health or safety or with a view to the protection of other persons (s2 (2) (a) (b) MHA). In the case of section 3 MHA the AMHP may make an application for admission in respect of a person on grounds that they are suffering from a mental disorder of nature or degree which makes it appropriate for them to receive medical treatment in a hospital and it is necessary for the health and safety of the person or for the protection of other persons for them to receive medical treatment in a hospital, and appropriate medical treatment is available.

Searching for an understanding of the individual involved the AMHP interpreting background information about the person provided by other sources, combined with their own face-to-face interaction with the person being assessed. This was a non-linear process in which the two different perspectives are informing and informed by the other. The AMHP was a mediator in the process of understanding the individual, yet this mediator role was situated in the context that stories told by family members and professionals usually carried a lot of weight in comparison to the views of the person assessed. Although this was not always the case, as I will discuss below, the relationship between the AMHP, family and professionals was nonetheless most often situated in terms of an unequal coalition that underpinned the AMHP's understanding of the individual at the centre of the MHA assessment. An example in the data where this was not always the case involved one participant (7) who closely questioned and challenged the family's perceptions about the person being assessed under the MHA (see below). It is also very likely that the perspectives of others could be given less priority in referrals that are not accepted by AMHPs or do not result in detention.

Examples in the data illustrating that the AMHP was a mediator in the process of understanding the individual is exemplified in the entire case story from Participant 9 (Appendix 7) where the description of the MHA assessment demonstrated that the AMHP searched for an understanding of the individual that was reached in part through interpreting the family's understanding. Having gained this understanding the AMHP's description of the interview with the person assessed is that they are motivated to hear from the person themselves as opposed to simply accepting the understanding of others in the absence of efforts to balance this with the perspective of the person assessed. The AMHP's description in the entire case story reveals that the lack of dialogue with the person assessed is a source of frustration. The significant issue in terms of giving more weight to the story of the close family member than to that of the person assessed is that the close family member could engage in a rational dialogue with the AMHP; this contrasts with the person assessed whose initial dialogue consisted of shouting "go away" as the AMHP

tried to speak with him through a letter box before the police forced entry into his home where further attempts to engage in dialogue were attempted. The context of the contrasting ability to form dialogue is striking, demonstrating how this renders the views of family members as holding more weight.

Further evidence of the AMHP mediator role is found in the case story of Participant 7 who, in contrast to most participants, demonstrated that the mediator role can be focused on the views of the person assessed over the views of family members. The case involved a MHA assessment in the community where the person was assessed following reports of serious self-neglect. A close family member had provided a story of the person's room being cluttered and disorganised, using this as evidence to suggest the person was neglecting themselves. The AMHP disputes this interpretation and privileges the view of the person assessed by supporting the perception that there is nothing wrong with the room and that, to the contrary, it is well organised. The AMHP in question did not initially detain the person and draws on reasons to support this:

'So, there was all this persecutory flavour to his thinking at the time. And he looks slightly dishevelled, his flat was a room, and mum says that it was in a state, it wasn't, it was reasonably organised'. (Participant 7).

Interestingly, as well as being the only example provided by participants where the views of the person assessed were given more weight, it is also the only assessment that resulted in a delay in making an application to detain the person in hospital to try a less restrictive intervention of the Home Treatment Team, who would visit the person several times a day in their home. It would be tempting to view this as a positive outcome where, on the face of it, giving more weight to the views of the person assessed led to a less restrictive outcome. However, the person had a serious medical condition ancillary to their mental health problems, which necessitated urgent surgical intervention after the person was eventually admitted to hospital. This shows that less

restrictive options cannot be reduced to a simple equation of autonomy being the preferable to coercion in every situation.

The AMHP searched for an understanding of the individual to interpret whether an argument could be made that the legal grounds for detention were met and if so whether an application for detention ought to be made. Several factors were influential in how they did this. The AMHP's perspective was wide, their understanding reached in part through interpreting the family's views; this involved getting a sense of the individual in their environment in relation to others as opposed to a narrow perception of the individual in isolation from the impact on and from others.

An example of the wide and relational perspective is found in the data of one of the participants who described an assessment in hospital, which involved interpreting whether an argument could be made that the legal grounds for section 3 MHA were met and whether they should make this application:

'But I have, have to say prior to being, prior to doing that as well I obviously had a conversation with the nearest relative, her daughter, and they expressed concerns about her before and they thought that she needed to be in hospital and they thought that she needs to be there for a period of time to, to get some sort of treatment. Because they'd, they'd been supporting her for a long while and she was quite, it sounds like she was quite a strong-willed person with a not very direct, you know, couldn't, wouldn't, wouldn't take any kind of, um, guidance I suppose, and they weren't able to look after her in, in the day times because they were all at work. So that was it'.
(Participant 11).

The factors that appeared most significant for the AMHPs when taking into consideration these different perspectives involved the person's social and

family situation where the views of other people and particularly the impact on others is most influential. In practice consideration of the perspectives of others appear to be privileged over views or wishes of the person assessed.

Searching for an understanding of the individual operated in the context of AMHP participants trying to understand the individual referred to them. Other important factors taken into consideration involve interpreting historical events, unusual beliefs and or behaviour, the participation of the person being assessed when interviewed face-to-face, and contradictions in understanding between the views of the person being assessed and those of others. Historical events are important in the AMHP understanding the troubles and play a role in the interpretation of these problems, further cementing the warrant for action that something needs to be done.

Two examples are illustrative of this:

'You feel someone is damned by their history, to some extent.' (Participant 2).

The participants explained:

'That feels a bit unfair, almost, asking someone to share their story with you in order that you can assess the situation where what has gone before determines very much what is going to happen, which is fine because that's only part of the assessment. You shouldn't do an assessment just on a 15-minute conversation with someone you've never met before, that would be really bad practice. But you're asking for quite a lot for someone, to be fair you're taking quite a lot away, but it feels like when they've got very little chance to change what's most likely to be the decision, it seems a bit unfair'. (Participant 2).

'Lots of stuff was historical rather than current about his presentation, so there was lots of disengagement from, from medication, lots of issues around, um, his relationship with his mother'.
(Participant 11).

The quote above by participant 11 emphasises that in this case the history of the person was important in providing context for the current concerns.

Section 1 (1) MHA provides that the Act has effect with respect to the reception, care and treatment of people who are considered to be mentally disordered. For the purposes of the MHA mental disorder means 'any disorder or disability of the mind' (s1 (2) MHA). Unusual beliefs or behaviour were an important consideration for AMHPs in co-constructing stories of troubles to understand the individual. They interpreted unusual beliefs and behaviour by gaining an understanding of the perspective of others and from their own perception of the person. Understanding the perspectives of others involves the AMHP searching for an understanding of the impact of unusual beliefs and or behaviour on other people, providing a further foundation for the AMHP on which to provide a warrant for action in terms of the person meeting the legal criteria for the MHA 1983. The evidence of unusual beliefs and or behaviour are interwoven with the idea of feasibility and the rationale for the decision made: whether to detain the person in hospital.

The following examples are illustrative of this:

'The difficulty, I felt, in this assessment was in some ways he put on a very good show, he was guarded about most of his delusional ideas and he didn't display any thought disorder or any of the cognitive aspects of psychosis, but he was clearly still quite deluded, although he was managing to mask that to some extent, and he was completely unable to keep

*himself safe while he was in the community
because these delusions were so prominent’.*

(Participant 4).

The implication is that the unusual beliefs or behaviour do not necessarily need to manifest during the interview with the AMHP for the AMHP to feel satisfied that the grounds are met, although this does appear to add an extra layer of difficulty for this participant in matching the presentation of the person assessed to the legal grounds of someone ‘suffering from a mental disorder of a nature or degree’ provided in section 2 and s3 MHA. Here, understanding the individual and situation causing concern were understood through the lens of others and the history of the person. Interestingly, the AMHP did not see signs of a ‘nature or degree’ of mental disorder during the face to face interview; this was framed as the person masking and being guarded as opposed to there being no degree of mental disorder.

The following two quotes illustrate that gaining an understanding of unusual beliefs and or behaviour provides a further warrant for action in terms of the person meeting the legal criteria for the MHA 1983:

*‘I think his thinking being so disordered and the fact
that he obviously didn’t have capacity. I don’t think
he could have given consistent consent. I think his
thinking was jumping every few minutes, he was
jumping from different topic to different topic. He
couldn’t really think in a coherent or structured
fashion. Even if he said I want to be admitted, he
didn’t have the ability, I don’t think he even knew...
he might have known what the admission vaguely
would involve but he also thought he was a ninja
doing work for... he was involved in some kind of
conspiracy in the heat he was acting within’.*

(Participant 6).

'behaviour being bizarre, he started isolating himself more and more, locking himself in the room and there was an issue that he'd wrapped some clothing around his left hand, and this is a gentleman that also has a history of diabetes. He's not been taking his... he's also allegedly stopped taking his physical health medication'. (Participant 7).

The legal requirement to interview the person in a suitable manner is emphasised and represents how the law structures practice. Section 13(2) MHA provides that before making an application for admission of a person to hospital the AMHP shall interview the person in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

The participation and perceived demeanour of the person during the face-to-face interview with the AMHP was a related factor, further informed by an emerging understanding of the individual. The face-to-face interviews were an important component in the assessment, but the AMHP participants undertook a much wider assessment overall, which involved calibrating the collateral information, comprising different stakeholder views, with their own impressions of the person during a face to face meeting with the person. These encounters were situated in tension between the AMHP duty to follow the law by interviewing the person in a suitable manner and the search for a constructive and meaningful dialogue with the person, which was often characterized as being difficult to achieve. The interview itself was often characterized as a site of distress for the person being assessed, where interpreting understanding based on their participation and demeanour may be on the back-drop of forcing entry to their home with a warrant and persevering to interview them despite an unwillingness or inability on their part to participate. The AMHP therefore walks a tightrope between coercion and collaboration where they acknowledge that the assessment is experienced as coercive for the person being assessed, yet

despite this there is also a sense of inevitability in the view that the law will be experienced in this coercive way:

‘So, it’s a kind of tricky thing between getting enough evidence to decide to detain, and if you decide not to detain, making sure you’ve got all the evidence and you’ve made that decision based on all the evidence. But once you’ve got enough evidence for this person, unless there is a therapeutic reason – and to be fair, that should be the care team doing that, although you can try and make it therapeutic as well, we’re all mental health practitioners, we should be trying to interact in a therapeutic and meaningful way and you always have this dream that could be a transformative experience then, but mostly they’re not, emotionally pretty administrative and quite distressing for clients and not. So, there is that tension’. (Participant 4).

The quote below demonstrates that the search for meaningful dialogue with the person assessed was difficult to achieve:

‘I think the decision was based on the fact that he could not engage with us. He could not form any, any kind of conversation about his illness. He would just make comments like “kill me, kill me”, um, “kill yourselves”, um, you know’. (Participant 11).

Contradictions in understanding between the person assessed and others were a prominent feature that emerged from the data. These contradictions surfaced during the face-to-face interview with the person. They involved a disjunction between the views about the person, notably from professionals and family members, and those of the person being assessed, leading to contradictions in

perceptions about the troubles and problems from different standpoints. The following two examples are illustrative of this:

‘So, when we saw him, he stated very clearly that he did not want to remain in hospital, but he had agreed to remain, but he didn’t want to remain. It was very clear that he was taking his medication willingly, that he wanted to take it, that he felt it helped, even though when asked directly about how he’d originally come into hospital, he said well, he didn’t think he was unwell, even though he accepted the actual description that was given at the time by the doctor who assessed him which indicated he was unwell’. (Participant 1).

The quote highlights that there was a sense of incongruity associated with the contradictions in understanding and disjunction of views. Here the participant describes that the person ‘agrees to remain’ but ‘does not want to’ ‘agrees to take medication’ but does ‘not think he was unwell’ but ‘accepted the description of the doctor that he was unwell’. This disjunctive dialogue is perhaps indicative of the power imbalance between the parties and the person assessed.

The quote below is also illustrative of the contradictions in understanding surfacing during the face to face interview with the person:

‘So, through speaking to her, she, I don’t know if it wasn’t, if she did have insight or she didn’t, cos she didn’t think there was anything wrong with her. Despite her attempts to kill herself, her wanting to die, her not liking herself, her almost not liking who she is and she’s been like for that for a long time, she was not willing to engage in a conversation with her even, you know, having a, admission in hospital

just to assess her mental state, assess if treatment is necessary, assess what's going on for her'.
(Participant 9).

4. Theme 3: Understanding the situation causing concern

This theme deals with how participants describe participation in the process of understanding and meaning-making about the situation causing concern that has led to a MHA assessment. This theme relates to how participants describe putting the pieces of the referral together in their search for understanding about what has led to the MHA assessment. This captures how participants talk about the relevant circumstances of the case. I outline the role of perspectives on risk and the community, and deal with questions of feasibility and the availability of community support options, which were concepts put to work by AMHPs in their case stories.

A component of section 13 (2) MHA is important here, namely the requirement that before making an application for the admission of a person in hospital an AMHP shall satisfy themselves that detention in a hospital is in ***all the circumstances of the case*** (my emphasis) the most appropriate way of providing the care and medical treatment of which the person stands in need.

It was not merely the presence of risk that influenced how AMHPs understood and responded to the situation, but also concern about how the risk impacted on others, considering the proximity to harm of people affected, including the proximity to harm of the person referred. Preventing tangible harm was the focus as opposed to preventing the existence of risk. Some risks could be tolerated, such as the case of the young person who had tried to hang themselves; here the AMHP was willing to seek alternatives to hospital admission if the person was able to establish a therapeutic alliance with practitioners. In the event this alliance was not possible so a compulsory admission followed. The AMHP determined this in the face to face interview with the person where effort was made to offer less restrictive options to hospital admission. This approach contrasted with other cases where harm to

others was a more prominent issue, for example where a person assessed had physically assaulted his partner and was making threats to physically assault his daughter; here the AMHP was less inclined to pursue alternatives to hospital admission. Both cases resulted in the same outcome: detention under the MHA. However, the process was more likely to include a serious pursuit of alternatives to in-patient admission where harm to self was the risk in question. This point is further demonstrated in the account of Participant 7 who described an assessment where the main risk was self-neglect. Here the AMHP delayed making an application for 12 days to enable the Home Treatment Team to be tried as a less restrictive option.

The stories that emerged highlighted that AMHPs were faced with a call from referrers that 'something needs to be done' in relation to a problem situation, based on concerns about the feasibility of allowing it to continue to evolve that was called into question by other people involved. Understanding the situation causing concern is a relational and temporal process where AMHP participants took into consideration different perspectives such as those of family members or mental health professionals. Using the law in this terrain of social work is a situated practice: situated in the context of other peoples' stories about a someone's troubles and the impact of those troubles on both the person and others.

4.1 Family members' or carers' perspectives on what needs to be done

Views of family or a carer were influential when considering whether the person met the criteria for detention under either section 2 or section 3 MHA. The AMHP obtained a story from the carer or family member and interpreted the concerns against the feasibility of these people being exposed to the risks in question in the short-term future. The emphasis was not only on whether the statutory criteria of the MHA 1983 fitted with the pathology of the person being assessed under the MHA; it also comprised a wide-angle perspective on whether the statutory criteria fitted with the stories told by others. The statutory

criteria were therefore applied to the individual based on relational understandings obtained about them from other people.

A good example of this is the entire case story of Participant 9 (Appendix 7) who emphasised the influence of the close family member when considering whether the person assessed met the legal criteria for detention under either section 2 or section 3 MHA.

4.2 Risk to family and others

The grounds of risk outlined in section 2 (2) (b) MHA provide that the AMHP needs to consider whether the person ought to be detained in the interests of their own health or safety or with a view to the protection of others. The risk grounds in section 3 (2) (c) MHA provide that the AMHP needs to consider whether it is necessary for the health or safety of the person or for the protection of another person that the person should receive treatment.

The AMHPs' interpretation of the situation causing concern involved them thinking about the legal criteria for section 2 or section 3 against the different perspectives of concern. Specific risks were positioned by the AMHPs in relation to the categories of risk to self and risk to others, although there was often an overlap between these. Interpreting and understanding risk to family members and others was influential and typically linked to the person being assessed showing signs or symptoms of mental disorder. The needs and rights of family members and others were given a prominent position where AMHPs privileged protecting them from harm that was reasonably foreseeable, outweighing a right to liberty of the person assessed. Fear plays an important part in the quote below:

'There were reports of physically aggressive behaviour towards his mother who is the main caregiver and he lives at home, not only with his mother, with three other siblings, one who also has a diagnosis of autism, a three-year-old. There were

reports of an assault on mother in the summer of last year because mum kept trying to say to him, no you have to do this, you have to do that. And I think because he couldn't manage mum's frequent questions about his personal hygiene, he found it so difficult, so kind of lashed out at mother. So, since that incident, mother got really frightened and stopped actually challenging him on certain things to do with his personal hygiene'. (Participant 8).

The quote by Participant 8 highlights a nuanced coercion over autonomy. For all participants, this involved a complex juxtaposition of coercion and autonomy where privileging the needs and rights of family members was aimed at protecting them from harm. This involved the person assessed having their right to liberty outweighed. However, this was to promote the autonomy of the person assessed in the longer term and to restore the social relations that had been ruptured. In this way coercion and autonomy are closely related and intertwined with both complementary and competing imperatives.

4.3 Risk to health and safety

Doing the work to understand the situation also involved the AMHP interpreting risk and concerns that focus more discernibly on the individual characteristics of the person being assessed. This involved the AMHP considering risk to health and safety of the person assessed under the MHA, the AMHP bringing in their thoughts about the person alongside the views of family:

'The nature of the risks involved were primarily the young man would be to his own health I think and has damaged his... he may not be able to function at all, if he can't sleep, his mental state is only going to deteriorate, he hadn't slept for about four or five days, he's becoming irritable, aggressive. The situation was only going to deteriorate unless there

was some kind of medical intervention'. (Participant 6).

Understanding the situation causing concern involved a wide social perspective, providing depth to a medical perspective. This is addressed by the discussion in chapter 6 under 'socio-medical-juridical perspective'.

5. Theme 4: Community versus Containment

This theme deals with how participants describe weighing up the choice between detaining a person in hospital against them being in the community. This theme relates to the organised response by AMHPs, in the form of social control, to acute mental distress when associated with crises. I now provide an overview of the theme of community versus containment. In doing so I identify the concepts of feasibility, trust and containing the situation as important concepts in AMHPs' case stories. The use of law here is a situated and temporal practice to decide whether the person ought to be in hospital, where AMHPs think the risks are better contained, or whether they can be in the community where uncertainty and a lack of containment are implicated.

5.1 Feasibility of being in the community

Feasibility arguments are influential in considering the different spaces of community and containment (in hospital) and are related to the AMHPs' formulation of problems arising from the interpretation of troubles. The AMHPs' thinking about the notion of hospital versus community was dominated by feasibility arguments. The question they grapple with when assessing someone in the community is about whether it is feasible for them to *remain* in the community, as opposed to when they assess someone in hospital where the question becomes whether the person is *ready* to be in the community. In the quote below the AMHP described a person who was assessed in hospital where the argument is made that the person was not ready to be in the community. Here the AMHP draws on feasibility arguments to justify that the person is not ready to be in the community by illustrating that the person would

not be safe there. Risks are emphasised as a rationale for containment in hospital instead.

Risks are emphasised as a rationale for containment in hospital as opposed to being in the community:

‘although he didn’t believe that he had a mental disorder, but the circumstances of the case, in the level of risk incident that had led him coming into hospital, and he had absconded and been brought back to hospital in quite risky situations, were such that he would not be safe in the community’.

(Participant 4).

This was in contrast with the case of a MHA assessment with a person already in hospital, where concern about the feasibility of the family member *remaining in hospital* was highlighted:

‘When I spoke to his sister she said, we had quite a long discussion, she was quite wary about him remaining in hospital too long’. (Participant 11).

5.2 Hospital as a place to enable plans to be put in place for the future

In choosing where the person assessed should to be located, AMHPs acknowledged that hospital was not a desirable outcome for the person assessed because it would be distressing, inconvenient and disruptive. The majority noted that, in the case of assessing someone who was already an in-patient, the decision to detain them was partly based on the judgement that community support plans and arrangements were not yet in place; participants indicated that the hospital is an instrumental location where this end could be most effectively achieved. Similarly, participants who told the story of an assessment of a person in the community spoke of hospital as a site where plans could be put in place to address the situation causing concern. The

hospital made these plans possible because of the containment it offered, which in most cases was considered a desirable outcome to address the difficult situations. The emphasis on the importance of admission in terms of a space to enable plans to be put in place and for the situations and problems encountered to be contained provides an interesting contrast with the rather narrower purpose of assessment and treatment of mental disorder provided by section 2 and section 3 MHA.

The data provide evidence of the decision to detain being based on community support options not being in place yet. The description provided by Participant 3 below was made in the context of undertaking a MHA assessment in hospital where they were not satisfied that a feasible discharge plan was in place to prevent the person being detained under section 3 MHA. When the AMHP refers to 'all three of us' they are referring to both doctors and themselves. The implication of this is that if there was such a plan in place then this would have opened the possibility of not detaining the person:

'We in our turn, all three of us, were very clear that we didn't think there was any safe plan which would allow him to be discharged home. We felt it essential that there was a thorough assessment of what had happened and an appropriate discharge plan formulated'. (Participant 3).

In addition to the hospital being considered useful in terms of the utility of enabling plans to be put in place, the AMHPs also appear to be influenced by the quality of plans in relation to whether they are considered robust enough as a foundation on which a person can be discharged back into the community. The types of plans considered relevant to participants in their use of the MHA appear to focus particularly on supervision of the person in the community. None of the participants spoke about considering a Community Treatment Order (CTO) to achieve this. The following quote illustrates the concern that plans should be robust and adequate to act as a foundation to discharge the

person; the implication is that if such plans were in place this could avoid the person being detained:

‘So, our feeling was that he was unwell and that he was vulnerable, that his circumstances weren’t as secure as he thought, and we thought there was very good reason for detaining him a little bit longer to enable Section 17 leave, and that seemed like an entirely reasonable rationale for proceeding further, and because he’d said he wanted to go home, even though he’s agreeing to take medication, we thought it would be premature for him to go’. (Participant 1).

5.3 Trust

The notion of trust appears to be important for participants when thinking about community on the one hand and containment on the other. It operated at several different intersections between the juxtaposition of community and containment. There was, for most participants, a lack of trust in the hospital as an institution; however, this was nuanced to some degree as there appears to be a higher level of trust in ‘our’ ward, by which participants referred to the admissions ward in their local area. Paradoxically there is also a lack of trust in the person assessed to be able to leave hospital. Trust also operates in relation to whether the person assessed can be trusted to engage with mental health services in the community, a lack of trust here indicating consideration and justification of the need for containment. This also included a general sense of whether the person could be trusted to be in the community per se. In the quote below the participant seems to equate the use of detention as a response to the idea that ‘being voluntary’ leads to ambiguity, whereas being detained is equated with eliminating uncertainty:

‘We were all concerned that in the light of his history he could well change his mind and try to leave if he

were voluntary, and however much you try to plan these things, we all know that things go wrong on wards. So, there's an element sometimes of safety first, particularly almost certainly going to somewhere away from here. If it had been our triage ward I could have gone up and said, 'look, this is what we're doing'. (Participant 2).

Participant 2 highlights that the person could change their mind and try to leave the hospital if admitted voluntarily. The implication of this is that the person could, in theory, leave the hospital in a vulnerable state, or might need to be detained under short term holding powers to enable another MHA assessment. If the person left hospital then the crisis that led to the admission might re-occur. If they are detained under holding powers then another MHA assessment might lead to a suggestion by other professionals that the person should have been detained in the first place. There is also a suggestion that no amount of planning or communication with the ward would be enough to contain the person, there is also the sense that something could go wrong if the person was admitted informally. The AMHP was concerned that not being detained left the situation uncontained, despite that the person would be admitted to a psychiatric ward. This might suggest a sense that Participant 2 would be less likely to be blamed if things went wrong if the person was detained. When Participant 2 makes a distinction between a local and an out of area ward he appears to be suggesting that things would be less likely to go wrong, and therefore enable an informal admission, if the person was admitted locally. An admission to an out of area bed could involve admission to a hospital hundreds of miles away where the AMHP has no relationship with staff. Here, trust operates in several different layers. There is distrust in the person admitted because 'they might change their mind', distrust in the hospital to manage the person informally 'because things go wrong on wards', and a sense that trust in the process of admitting the person informally would increase if they were admitted to a local bed.

5.4 Medication in the community

Medication was an important consideration for most participants in relation to balancing the need for community versus containment. This was often in the context of the person assessed in the community not wanting to take the psychiatric medication that was prescribed for them or, in the case of assessments in hospital, the person not being relied upon to continue taking medication if not remaining in hospital. This is linked to the feasibility of community or containment as the desired response to the situation.

The data provide evidence of the AMHP feeling unable to rely on the person to continue taking medication unless in hospital, for example in the case story of Participant 4 who acknowledged that the person assessed knew that they needed to say that they would take medication, the implication here being that they also recognized the importance of agreeing to take medication in the community as a ticket out of hospital. The AMHP described feeling unable to rely on the assurances given because of their perceived lack of understanding about why they needed medication:

'He didn't believe he was mentally unwell, he knew if he agreed to take some medication orally he might be able to go out of the hospital, but that wasn't... so I couldn't rely that he would and without a greater level of his understanding of what had been going on for years and what could continue go on unless something changed'. (Participant 4).

The implication here is that it was important for the person assessed to acknowledge that they needed medication along with surrendering to the view that they were suffering from a mental disorder, or to demonstrate an understanding of and acquiescence to their diagnosis (See Rosenhan 1973), for the AMHP to feel that they could rely on them to continue taking medication. In this context, words to this effect from the person assessed were not enough; the AMHP looked beyond the interview with the person assessed, taking

account of observations of the person carried out and recorded in the medical notes. Another example of this is in the description of one AMHP (Participant 4) who described the person assessed as 'putting on a good show' in the assessment and described that this was contrary to accounts of their views and behaviour recorded since their admission to hospital.

Medication in the community was not considered in isolation from wider social factors. For AMHPs assessing people in hospital, a wider social perspective is also used where vulnerability of the person and their social circumstances sometimes outweighed the fact that they could be relied on to take medication in the community, thus tipping the balance for the person being detained. The quote from Participant 1 below illustrates this. Here, the AMHP was satisfied that they could rely on the person to take medication but was concerned that the person was still too vulnerable to leave hospital because his social circumstances were not adequate to enable him to be discharged. The AMHP in this case thought that graded leave under s17 MHA was needed:

'So, our feeling was that he was unwell and that he was vulnerable, that his circumstances weren't as secure as he thought, and we thought there was very good reason for detaining him a little bit longer to enable Section 17 leave, and that seemed like an entirely reasonable rationale for proceeding further, and because he'd said he wanted to go home, even though he's agreeing to take medication, we thought it would be premature for him to go'. (Participant 1).

The reliance on medication in the community, along with other factors outlined above as factors taken into consideration by AMHPs when they assessed someone in hospital, reveals that weighing up community versus containment when someone was already detained in hospital brought with it a unique set of challenges. In contrast to assessments undertaken in the community, the AMHPs did not get up close to the person's social situation and the heat had been taken out of the situation causing concern that had led to them being in

hospital. The quote from Participant 4 illustrates that whilst she considered the assessment straightforward because there were high risks to others, she considers that assessing a person's social circumstances on a ward is difficult, giving the example of not being able to assess whether someone has enough food in the house. The implication here is that the AMHP could assess this if they were doing the assessment in the home of the person:

'On the ward, you don't see someone's living environment. It was easy in this case because the risks were quite discrete and significant, and they weren't about getting locked out of his house or a level of disorganisation and not having enough to eat or any of those things which are very serious risks which need to be... but you can't see them and evaluate them on a ward and so you may... I worry that either on the one hand on ward assessments either you're just continuing the medical thing, so you're more likely to detain because they're already in there and this is just a continuation, you don't have the feeling of dragging someone kicking and screaming off the streets, which you do on a community assessment. So, the violence of it is reduced'.

(Participant 4).

5.5 Ability of family to cope

The ability, or conversely the inability, of family to cope with the person was strongly associated with lack of trust in the person to be in the community and was outlined by all participants in their case stories. All participants were influenced by this, and in most cases it was a key component in deciding between the person being detained in hospital or being discharged to or remaining in the community. The inability of family to cope and the subsequent removal of this support network in the community was a context for AMHPs

perceiving a lack of trust in the person to be in the community, as the family support network could no longer support and contain them. The quote below highlights that the family's ability to cope was sometimes associated with them wanting the person admitted to hospital. The implication here is that the family and the AMHP considered that the only way to replace this family support network was an admission to hospital:

'His father was the nearest relative and I'd spoken to his father before back in August. Both the parents were supportive of him being admitted back to hospital again, even if it was under the Mental Health Act. I think they were just concerned about the son's presentation. So, both the parents, who were quite closely involved in his care, it didn't seem to be a family where there was neglect or emotional abuse or anything like that, it seemed to be quite a warm, cohesive family but they were both supportive of their son being admitted to hospital'. (Participant 6).

An inability to cope was not only associated with an inability to sustain a role as a carer because of concern for the person's mental health. It was also associated with family members being concerned for their own safety, as illustrated in the quote below from Participant 9:

'Um, she was worried about being left on her own. She said, "I don't stay with him on my own", um, cos he, he, he threatened her but in a psychotic kind of ...because of his thoughts or his delusions that he's having, so she's unsure. She didn't know what he was doing, he's unpredictable'. (Participant 9).

5.6 Feasibility - Community support options

Feasibility arguments appear to be an important component for participants navigating the terrain of community versus containment, and in doing so thinking about hospital and community as spaces where problematic situations are located. The feasibility of community support options - the 'less restrictive' option that it is necessary for the AMHP to consider - were put to work by most participants in relation to their feasibility. This incorporated both their *feasibility*, in other words was this a feasible way of addressing the situation, and their *availability*, in other words a certain plan or resource might work in addressing the situation but may not be available.

Feasibility of alternatives to detention in hospital appeared to be linked with an ability to involve the person assessed in the alternative scenario, which to a large extent required at least some form of ability on the person concerned to participate in going along with it, which itself required a dialogue and some rapport between the AMHP, other professionals, and the person assessed:

'There wouldn't have been any social care intervention or any kind of community intervention that would have limited the risks, given the firmness with which he held his delusions and the recentness of the risks and the extreme... they weren't that extreme, he hadn't killed anyone and he hadn't actually been run down by a train but they were quite extreme risks, so we're drawing attention to him'. (Participant 4).

This contrasted with Participant 7 who chose not to make an application for detention, delaying making an application for 12 days, having received two

medical recommendations from the doctors present stating that the person should, in the view of the doctors, be detained in hospital³:

'After the assessment, looking at the law that yes, he met the criteria for him to go into hospital really to be assessed, because he hasn't been to hospital for a very long time. He's been managed in the community for a long time. However, he was still agreeing, though slightly reluctantly, to home treatment input and the other concern about the physical health that he will do something about it. So, the two doctors agreed that they needed to make a recommendation based on his presentation on the day. The doctors, they were insisting that yes, he needs to go into hospital compulsorily, whatever, and I still think that yes, I know that he's unwell, however I would like to use a less restrictive means of... I have 14 days within which really to make an application. So, the plan would be to try and get the home treatment team in'. (Participant 7).

The significance of this theme relates to the inherent challenges inhabited by the AMHP in the spaces between autonomy and coercion, and the perspectives employed by the AMHP to balance these tensions. These are addressed further in the discussion at chapter 6.

³ An AMHP has 14 days to make an application for section 2 or section 3 Mental Health Act 1983 (as amended), on the basis of receiving two valid medical recommendations. In this case, the AMHP decided to allow time for the person to receive a less restrictive alternative to admission to hospital. This involved daily contact with a home treatment team. This plan broke down and resulted in the subsequent application on day 12.

6. Theme 5: Relationships and resources

This theme deals with how participants describe how the professional relationships and resources encountered during the process of using the law in practice influence their decision making. This theme relates to the importance of logistics and inter-agency working, where challenges to AMHP autonomy often emerge. Using the law in practice involves a logistical undertaking where relationships and resources are important factors, in the form of inter-professional and inter-agency working relationships. A key consideration in these is the concept of autonomy as an AMHP. The relationship most significant was that with the independent doctor: the doctor the AMHP chooses to take part in the assessment in contrast to the doctor with responsibility for making a first medical recommendation. The Police were also a key relationship for most of those AMHPs who told a case story of using the law in an assessment based in the community. Overall, the relationship with the Police was described as positive, except for one participant who described their experience of this relationship as a challenge to their professional autonomy.

In terms of the resources that form an important component of the logistical undertaking of using the MHA in practice, the psychiatric bed was the most significant for those recounting assessments in the community and for those recounting assessments in hospitals that were outside of the geographical area where the AMHP worked and usually carried out assessments. Both situations arose because of a lack of availability of local psychiatric beds.

6.1 Autonomy as an AMHP

The notion of being autonomous was an important concept for the AMHPs. This was linked to both inter-agency and inter-professional working relationships, where autonomy was experienced both as a resource to be able to take the opposite view to medical colleagues involved in the MHA assessment and as a resource to share the same view about a person as the medical colleagues involved. Hence AMHPs emphasised their autonomy

notwithstanding their agreements with doctors, in other words the potential to disagree being the important factor. The quote below illustrates the importance of the concept of autonomy as being important to AMHPs in terms of the potential to disagree with medical colleagues:

'I mean okay I've been doing the job a long time now but I've always, it is really important to me to be autonomous. When I first qualified I got a reputation amongst colleagues for being one of the ASWs who said "no" most often actually. I think the reputation has subsided a bit, but I've always been very clear about my independence'. (Participant 2).

The AMHPs experienced challenges to their autonomy during inter-agency working with police where they felt their autonomy was acknowledged in principle but at the same time the working relationships between the different agencies was seen to undermine AMHP autonomy in practice. This is exemplified in the entire case story provided by Participant 9 (Appendix 7) who describes the police essentially acknowledging her autonomy "you're in charge" as a means of displacing their own legal powers.

Two AMHPs spoke of their autonomy as a resource that could be drawn on to make final decisions and to resolve disagreements; another spoke of their autonomy as a resource, both inter-professionally and between different agencies, for achieving a better outcome for the person being assessed in relation to the provision of accessing a specific resource.

6.2 Inter-professional working relationships

The independent s12 MHA doctor

The AMHP relationship with the independent section 12 (MHA) doctor appeared to be an important relationship and resource for the AMHP. This was, for most participants, a discernibly more significant working relationship than

that with the NHS Trust doctor who has often already made a medical recommendation. The relationship with the independent s12 approved doctor appears important in two respects: in terms of a best fit with the AMHP and best fit with the clinical needs of the person assessed. There is a requirement in some circumstances for the independent doctor to have expertise to match the needs and characteristics of the person assessed. However, there is also a sense that the AMHP participants chose which independent s12 doctor to use based upon their working relationship with that doctor where mutual respect was a highly-valued currency:

'I think it can be for complicated cases. There are two or three Section 12 doctors I will tend to use if for example I am assessing a young person 12/13/14, or an elderly person, or if there's complicated extra factors, because I need to have confidence that they're able to hold all that information, pull it together and make a good informed decision from their point-of-view. And someone that is good at interviewing, so I'm not having to nudge it along, or they've asked three or four questions and then they say yes, I'm ready to complete. I want a proper assessment to look at all the possible options and make sure we've been as thorough as we can'. (Participant 5).

6.3 Inter-agency working relationships

An AMHP who wishes to make an application to detain a person under the MHA can only do so if a bed is made available in a named hospital is made available by the responsible hospital trust. The MHA provides that it is the duty of the hospital trust to provide the bed. The Code of Practice to the Mental Health Act 1983 places the responsibility for locating the bed on the doctor. However, participants often found themselves in a position where they were pursuing a bed as they wished to make an application for detention (the

implication is that the doctor who had made the recommendation did not do this). A further issue for participants was a lack of psychiatric beds in some areas. Two participants recounted cases where the person detained was admitted to a hospital in geographical area outside of the borough where the AMHP worked. One of the problems with this for participant AMHPs was being asked to undertake an assessment in a different geographical location, sometimes many miles away. This is because when the MHA was amended in 2007, consideration of a section 3 did not fall on the local authority area where the person was located under section 2, but rather on the local authority from which the AMHP made the application for section 2. For example, if a person is detained under s2 by an AMHP in a London borough and, because of a shortage of psychiatric beds, is admitted to a bed in Manchester, then if a medical recommendation is then made for section 3 MHA by a Responsible Clinician in Manchester, then the duty to consider s3 MHA falls on an AMHP from the relevant local authority in London not an AMHP in Manchester.

The following quote illustrates the perception that placing a person 'out of area' is problematic both in terms of the experience of the person who is far away from family and for the AMHP, who may be faced with factoring in how a person would get from a hospital in a distant geographical location back to their home if they are not detained:

'They're far away from their friends and relatives. Where's this person going to be discharged to if we decide that he's not detainable? What's in place for that? How's he going to get from so far away to another borough? Is it the AMHP's role to actually kind of like negotiate those kind of like logistical things about getting someone back?'. (Participant 2).

There is thus some frustration and a lack of clear resources to enable someone to return home. The bed in the distant location will have been arranged by the

local mental health Trust, which will also have responsibilities to repatriate people they have arranged to be admitted to a distant location.

7. Conclusion

The findings outlined above illustrate the inherently socio-relational process involved when AMHPs use the law in practice. These were organised under five themes: 'understanding the referral situation'; 'understanding the individual; understanding the situation causing concern; 'community versus containment'; 'relationships and resources'. An in-depth understanding of the findings is addressed in chapter 6.

Chapter 6: Discussion

1. Introduction

The discussion comprises three parts. In the first I draw on practice theory (Bourdieu 1977), legal consciousness (Ewick and Sibley 1998; Sibley 2005) and street level bureaucracy (Lipksy 1980) to illuminate my findings, arguing that using the law in social work AMHP practice involves an embodied practice. In the second I discuss how the concept of legal literacy translates into practice when social work AMHPS use the law. And finally, I argue that social worker AMHPs perspectives can be described as socio-medical-juridical: that AMHPs enact the law in practice using a wide social perspective that provides depth to a medical perspective where the social and medical are not necessarily in tension with each other, leading to my proposition that different perspectives don't always equate with different decisions. This also includes perspectives on process not just perspectives on pathology or other characteristics of the person assessed.

The findings outlined in chapter 5 are discussed in this chapter to address the previous calls for an exploration of how legal literacy translates into practice (Braye, Preston-Shoot and Wigley 2011; Preston-Shoot and McKamy 2012). In doing so, the discussion also seeks to articulate the complexity of the task of using the law in social work AMHP practice. It also addresses the call by Campbell (2010) who proposes that in critically understanding how they are positioned across complex legal, organisational and human systems, mental health social workers may be better prepared to work with the ambiguities of the role (Campbell 2010), and thus contributes to a more searching analysis of the interplay between law and social work (Braye and Preston-Shoot 1990: 334).

The discussion uses my research questions as a reference point throughout: how do AMHPs use the law in practice in the context of assessment for admission to hospital under the MHA and how does the concept of legal literacy translate into social work AMHP practice? How does the AMHP employ

a social perspective when using the law in practice, and finally, how do AMHPs describe their work using the law in practice? What does this reveal about their priorities and the challenges they face?

2. Embodying the law in social work AMHP practice

When analysed drawing on Bourdieu's (1977) theory of practice, participants' accounts of using the law reveal it to be an inherently socio-relational undertaking, involving embodied practice. This refers to their practice being patterned and structured but not explained solely by them drawing explicitly on knowledge of legal rules contained in the MHA and related guidance. To call social work AMHP use of law an embodied practice is illustrated drawing on Calavita (2016) to debunk the perception of law as magisterial, containing its own internal logic. This places the embodied nature of law in further theoretical context by proposing that far from a closed system of logic the law is tightly interconnected with society (Calavita 2016), 'far from magisterial or above the fray, law is marked by all the frailties and hubris of humankind' (Calavita 2016: 5). In the context of the findings, this illustrates that whilst social work AMHP practice is shaped by the law, it also shapes it.

Its socio-relational nature refers to three elements: firstly, the implication of the different parties involved possessing varying degrees of status bestowed by titles, professional qualifications, and classifications: doctor, patient, AMHP, carer; secondly, the dynamic juridical field where the law is used, a field of constitutive power - the power to name: this person is detainable that person is not detainable under the MHA (the juridical field is also emphasised further in part two of this chapter); and thirdly, the concept of habitus, which recognises the importance of habits, dispositions and perceptions as guides to human action. Legal consciousness theory (Ewick and Sibley 1998; Sibley 2005) provides further understanding of the importance of process, where participation in the process of constructing whether someone is detainable involves interaction and meaning making over the duration of a MHA assessment.

Evidence for how this worked in the findings is contained in the entire case story of Participant 9 (Appendix 7), which provides evidence that the AMHP used the law as a framework that structured her practice. In this way, her practice was regulated and patterned by the external structures of the MHA. For example, at the point of receiving the referral, she describes working within the structure of the duty to consider an application for the person referred. This is also demonstrated when she spoke about using the warrant as a means of lawful intrusion on private and family life, and when she described the care taken to consult with the nearest relative. It is further demonstrated in the way that the case story turned to understanding the individual (theme 2) and understanding the situation causing concern (theme 3), where her practice was structured by the provisions of the MHA only applying to someone who has a mental disorder. Further evidence of the regulated and patterned practice framed by the external structure of the MHA occurred when she spoke about taking into consideration the relevant circumstances of the case when describing the main reasons influencing her to make an application to detain, which also involved seeking to understand the individual (theme 2) in relation to the grounds for section 2 MHA detention.

However, the account provided in the entire case story of Participant 9 did not merely highlight strict obedience to the provisions of the MHA, a sole pre-occupation with a rational-technical calculation of legal clauses to guide her action. This is in common with most case stories, which contain clear and deep structured traces of the MHA and evidence of adhering to legal rules; however, this occurred, overall, with a distinct absence of 'law talk' (Braye, Preston-Shoot and Wigley 2011). This is demonstrated in the account provided by Participant 9, revealing a lack of explicit reference to the legal clauses of the MHA, despite the description of her practice being clearly structured by it. An explicit reference to specific legal provisions rarely emerged in the interviews, although there were notable exceptions to this, particularly when the AMHP found themselves in a potentially difficult situation, for example the participant who spoke about assessing a younger person and ringing his AMHP colleague in a CAMHS team to check out the interface of the nearest relative and parental responsibility. The lack of 'law talk' in the findings does not however

reconcile with the law being absent from the case stories; rather it signals an acknowledgement that when it comes to using the law in social work AMHP practice the law is not, as Braye, Preston-Shoot and Wigley (2011) put it, simply 'in or out' of AMHP practice. The findings highlight and reinforce that the relationship between law and practice is much more nuanced and complex than this (Braye and Preston-Shoot 1990; Braye and Preston-Shoot 2006b; Braye, Preston-Shoot and Wigley 2011). The regulated and patterned nature of social work AMHP practice that culminated in the themes outlined in chapter 5, and illuminated by the entire case story, shows that understanding how social work AMHPs use the law in practice requires further consideration, in addition to the rational-technical application of legal rules, to explain how they use the law in practice.

When analysed drawing on Bourdieu's concept of habitus (Bourdieu 1977), the findings highlight that dispositions generate habits, perceptions and practices as a guide to how participants use the law. Evidence for how this works in the findings is provided in the example of the entire case story (Appendix 7) where the AMHP talks about the assessment involving a s135(1) MHA warrant. Here the legal grounds and powers available under the provisions of s135(1) MHA appear to be clear to the AMHP; she knows the limits and possibilities inherent in the legal provisions, for example that there is the power to take the person assessed out of his home and to take him to a place of safety. However, the exact clauses of s135(1) are not the only factor guiding her practice of using the law. The structured nature of habitus helps to explain this when she draws on her professional experience, describing how she would normally approach using a warrant, referring to what she has done in the past during similar circumstances. Her story describes a choice between letting things play out or taking the person out of the home because the shouting and non-engagement are detrimental to interviewing the person in a suitable manner as required by s13(2) MHA. The legal clauses did not provide an answer to what the AMHP should do. Instead she drew on her past experiences of using the law in similar circumstances, demonstrating a disposition to arrange an interview with the person in a contained setting that could be most conducive to a constructive dialogue; her account revealed that this disposition generated habits and

perceptions about how to achieve this. Habits and perceptions manifested when the AMHP contrasts this situation with previous warrants that she has experienced, explaining 'usually, you know, a s135 is used to remove the person', but it is common practice for AMHPs to assess the person in their home, reflecting that removing the person before assessing them is the 'last resort', and reiterating that the normal practice is to assess someone in their home, if they (the assessors) felt safe to do so. When faced with shouting and opposition from the person assessed, the disposition of the AMHP was to use the warrant to remove the person from their home to take them to hospital where they could be assessed in a more contained setting. This is demonstrated when she reflected that when she had entered the man's home 'this was a typical assessment' where you would have to 'whip them out to get them somewhere safe' (meaning take them out quickly to a place of safety). However, once the atmosphere in the assessment changed and she could obtain more constructive dialogue, then the AMHP describes feeling more relaxed herself. The disposition of the AMHP changed, generating habits, perceptions and practices that resulted in the AMHP using the warrant to interview the person in their own home as opposed to using it to remove the person to facilitate an interview.

Social capital manifests in the findings, emerging in the social connections and obligations between the AMHP and the other parties involved in the MHA assessment. This is then institutionalised in the form of 'title': AMHP, independent doctor, person suffering from a mental disorder, nearest relative, police officer. These titles that manifest social capital are referred to by Bourdieu as 'symbolic capital' defined as '...apprehended symbolically, in a relationship of knowledge' (Bourdieu in Richardson 1986: 255). How symbolic capital works in the themes and participants case stories will now be addressed.

Family members and professionals are situated in a more advantageous position because they have, in comparison with the person assessed, a better grip on symbolic capital; they occupy a better position of influence on the AMHP. This occurs largely in the context that their ability to articulate and build

rapport is enhanced in comparison to that of the person assessed, who may not be able to occupy such a position and therefore possesses less symbolic capital in the field. The findings, exemplified in the account of the entire case story of Participant 9, provide evidence that the social capital of the man assessed under the MHA was seriously diminished, largely because of his acute levels of mental distress, making elusive any kind of dialogue to explore enhancing his autonomy or considering less restrictive alternatives. Therefore, views of family members occupied a more influential space in the emphasis given to them by Participant 9, in common with most participants, when considering whether the man met the legal criteria for detention under the MHA. Further evidence of how symbolic capital works in the findings can be seen in the theme 'understanding the situation causing concern' (theme 3 chapter 5). Within this theme, the endeavour to find meaning drew on the views of family members and professionals alongside the AMHP's own interpretation of these issues. The emphasis for Participant 9 was not merely in determining whether the statutory criteria of the MHA 1983 fitted with the pathology of the man assessed; it also comprised a wide-angle perspective on whether the statutory criteria fitted with stories told by others, emphasising the influence of the close family member when considering whether the man assessed met the legal criteria for detention. Contrary to this approach, Participant 7 did, initially, give emphasis to the views of the person assessed over that of family members who wanted the person to be admitted to hospital, although within 12 days the man was then detained to hospital. The notion of social capital (Bourdieu 1977; 1990) enhances understanding of how legal consciousness (Ewick and Sibley 1998; Sibley 2005) works because in legal consciousness the participation between people in the construction of legality, that is the talk, interaction and meaning-making, does not explicitly account for the relevance of power. However, combining legal consciousness with Bourdieu's notion of capital brings power to the surface. This provides a deeper understanding of the way that power shapes whose voice is privileged within the participation in the construction of legality.

Symbolic capital is also apparent in the theme 'relationships and resources' (theme 5), which shows that using the law in practice involves a logistical

undertaking where relationships and resources are important factors. A key consideration here is that symbolic capital can be seen in the findings about the importance of the concept of AMHP autonomy; Participant 1 emphasised his autonomy notwithstanding agreeing with doctors that the man should be detained. The important factor for Participant 1 was the symbolic potential to disagree. The quote below illustrates the concept of autonomy as being important to AMHPs in terms of the potential to disagree with medical colleagues:

'I mean okay I've been doing the job a long time now but I've always, it is really important to me to be autonomous. When I first qualified I got a reputation amongst colleagues for being one of the ASWs who said "no" most often actually. I think the reputation has subsided a bit, but I've always been very clear about my independence'. (Participant 1).

Symbolic capital can also be seen in theme 5 where Participant 9 spoke about the inter-agency working challenges encountered in relationships with the police during an assessment. The relationship with the police posed challenges to her autonomy; she had a sense the police officers were using her autonomy against her in that it was used to undermine the working relationships and roles that were considered important for this autonomy to have meaning. The AMHP describes that in emphasising that she was in charge alone, her autonomy was undermined by the police stating a reason for not assisting with conveying the person to hospital: "well yes, it is your assessment, and you're the person responsible for this". This demonstrates that the resources of power, involving socially constructed legal texts and social relations with other professionals, can exist in tension. Maintaining symbolic capital might involve a struggle for position between those involved in the MHA assessment. The social connections between the AMHP and police are institutionalised into the form of job titles and apprehended in a relationship of knowledge. However, this finding demonstrates the possibility of misapprehension in these social connections. This can result in a struggle for the AMHP to draw effectively on symbolic

capital. The power resource of autonomy is often emphasised as the defining power of the AMHP: they are free to make autonomous decisions and cannot be directed to make decisions. However, when understood in the context of social capital, the power of autonomy is dependent on relationships with others, who might not be pulling in the same direction.

The concept of field (Bourdieu 1977) applied to the findings captures the idea that the conditions of the field of practice (juridical field) had an impact on how participants experienced and used the law. The specific conditions of the field highlighted in the findings under the theme of 'understanding the referral situation' (theme 1) are referred to as 'organisational issues' and 'an adversarial atmosphere accompanying the referral'. A brief definition of the term 'temporality' is required to foreshadow the discussion below. Temporality encompasses the notion of lived time experienced subjectively, as opposed to clock time (Van Manen (1990). The relevance of field is most notable in the findings in the way that temporality manifests and how organisational deficits and an adversarial atmosphere impact upon how AMHPs use the law (Ewick and Sibley; 1998; 2005). These conditions of the field (organisational issues and an adversarial atmosphere) are, drawing on Hertogh (2010), referred to here as the 'legal wind-chill factor'. The idea of a legal wind-chill factor is addressed in chapter 3, and in chapter 5 under theme 1, 'finding a bearing on the referral situation'.

How the concept of field works in the findings can be seen in the sense that the game is in play before the referral was even received by the AMHP. This is further cemented in the findings under theme 1, 'finding a bearing on the referral situation'. This involves a future orientation by the bidding of the referrer for a MHA assessment, often accompanied by providing 'good' reasons why the person should be detained. The relevance of participants receiving the referral within this temporal frame of understanding and experience can be elucidated by Bourdieu who proposes that in a game of football a good player positions himself or herself not where the ball is, but where the ball is about to land. In this instance, the forthcoming is not simply a possible, but it is already present in the configuration of the game, including the present

positions and postures of teammates and opponents (Bourdieu 2000: 208). The implication of this in terms of how AMHPs carry out assessments is that the outcome of detaining a person under the MHA was more than a possibility, it was present in the configuration of the game; family members and professionals, with greater symbolic capital than the person referred, occupied a position to articulate the good reasons for assessing the person. The crucial point here is that even prior to the AMHP receiving the referral and embarking on the process of using the law, this is envisaged by others as a solution to a problem. The field of law is already in play; the AMHP is brought onto the field where play has started even before they are entered. This is demonstrated in the findings under theme 1, 'understanding the referral situation'. Here, participants commenced their case stories by talking about the MHA assessment referral, which encompassed accounts of trouble and problems, and how these were interpreted by family and professionals who encountered the person before the AMHP became involved. This involved something serious happening in the recent past that framed the current concerns. An example of this within theme 1 involved the AMHP who recounted that the person she assessed had, in the recent past tied a belt around her neck attempting to hang herself. This event in the recent past was used as a bearing to consider the potential risk of harm occurring in the future, where stopping her from hanging herself again was the main concern. Further evidence for the outcome of detention in hospital being present in the configuration of the game occurs within theme 2, 'understanding the individual'. This theme illustrates that stories told by family members and professionals usually carried a lot of weight in comparison to the views of the person assessed. For example, Participant 11 demonstrates their understanding is reached in part through interpreting the family's understanding. The feasibility of the person *not* being in hospital as a response to contain the risk was the focus for participants. For example, Participant 4 described the risks to the person and other people in the context that the person had already absconded from hospital, and physically assaulted a family member. The AMHP described the feasibility of the person *not* being in hospital by suggesting that had the person not been detained then within a week there would be an event where someone would be hurt or the person would end up back in hospital. Understanding the findings through the lens of

field (Bourdieu 1977) adds further light on Campbell's (2010) focus on the coercive nature of social workers' role, as this coercive role emerges before the AMHP even receives the referral, and is not therefore limited to the decision to detain. Rather it permeates the entire process of a MHA assessment from start to finish.

The legal wind chill factor plays a part in shaping the terrain on which the game is configured. Drawing on street level bureaucracy theory (Lipsky 1980) provides meso level understandings of the findings, acknowledging the organisational factors impacting social work AMHP use of the law. In the context of how social work AMHPs experience the law in practice, the legal wind chill comes from two fronts. This first comes in the form of an adversarial atmosphere at the point of receiving the referral that is packaged with a sense of rupture in the life of the person referred where there is some form of opposition involved, usually in the form of opposition to mental health treatment and often associated with opposition between family members and between other professionals and the person assessed. This is demonstrated within theme 1, 'understanding the referral situation' in the example of Participant 8, who describes such opposition where the family could no longer cope with the behaviour and beliefs of the person because of the impact on family life. A community mental health team had been working with the person but was now opposing their continuation at home because they believed that the person's mental state was deteriorating. Opposition occurred here because the person assessed held very contrary views about what they considered best and crucially were opposed to being admitted to hospital. The second front of legal wind chill comes from the organisational factors that impact on the MHA referral and assessment process. For example, the findings clearly highlight under the theme of 'understanding the referral situation' (theme 1) that referrals, particularly those from hospital where the person referred was already an in-patient, were often made within timescales that placed AMHPs under pressure in terms of how they related to the law, for example having insufficient time to contact the nearest relative of the person because referrals were made by the ward with a small amount of time to run on a section 2 MHA accompanied by a medical recommendation for section 3 MHA.

The literature on how decisions are made under the MHA focuses on the practical nature of decision-making, which posits the 'practical' as somehow being indicative of a gap between law and practice. Following this perceived 'gap' between policy and practice the law has been characterised to be either discarded during the process of carrying out a MHA assessment (Quirk et al 2000), or moulded to practical purposes (Fistein et al 2016). These previous studies focus on outcomes and reasons for decisions that envisage decision-making under the MHA in terms of an event in time that emphasises a 'now' moment, where the decision whether to detain the person takes place in a discussion following the interview with the person assessed under the MHA: in other words, at the end of the face-to-face interview with the person assessed. My own findings, together with the subsequent analysis, focus on the processes, connections and relations involved in such decisions. Where the previous studies emphasise the practical nature of decision-making as separate to the law, my own findings emphasise the temporal nature of using the law in practice, rather than viewing the practical use of the law in terms of a 'gap' between the law on the statute books and the law enacted in practice. My theoretical assumptions accept the inherently practical nature of the law in practice, illuminating the permeability of law when put to work in the terrain of mental health practice. The previous studies (O'Hare et al 2013, Peay 2003, Fisten et al 2016, Quirk et al 2000) focus on reasons for someone being detained under the MHA and present a more concrete and calculative scenario following on from the framing of a MHA assessment as an event that is focused on the characteristics of the person assessed, where the views of professionals making these decisions are not related to the bidding, for example from family members and other professionals who may articulate good reasons to detain the person. My argument that law in practice is temporal and embodied reflects the emergent and contingent nature of the reasons to detain someone or not.

My findings extend those of Quirk et al (2000) by revealing that in addition to availability of alternatives to in-patient treatment, the *feasibility* of alternatives to in-patient hospital admission also influences decisions to detain someone under the MHA. In further contrast to the findings of Quirk et al (2000) that lack of availability of alternatives is related to a lack of time and support from other

professionals to put these plans in place, my findings reveal that using the law here involves a more nuanced and holistic interplay involving temporal understandings where the AMHP calibrates the history of the person, the present in terms of the demeanour of the person and their unusual beliefs or behaviour, and the future in terms of the impact of the mental disorder in balancing the available or feasible alternatives. In my findings, feasibility of alternatives to detention in hospital also appeared to be linked with the inability to involve the person assessed, linked to them experiencing acute mental distress.

3. Social work AMHP practice and legal literacy

The concept of legal literacy for social work practice (Braye and Preston-Shoot 2006b; Braye, Preston-Shoot, and Wigley 2011, Preston-Shoot and McKimm 2012) is used to conceptualise and organise a discussion of the findings below. Legal literacy refers to the relevant knowledge, skills and values drawn on by social work practitioners, including AMHPs, to make a connection between legal rules and the professional priorities and objectives of ethical practice (Preston-Shoot and McKimm 2012). This is composed of three pillars: doing things right, referring to the need for knowledgeable use of legal rules; doing right things, referring to law's interface with values; and rights thinking, referring to action by reference to human rights (Braye and Preston-Shoot 2006b; Preston-Shoot and McKimm 2012).

These concepts emerge in the findings with a dynamic and fluid overlap between the pillars of knowledgeable use of legal rules and law's interface with values, where AMHPs' ability to do right things with the law is closely associated with a high level of confidence in a knowledgeable use of the law. Of the three pillars of legal literacy applied to the findings, the weakest is action by reference to human rights, referred to as rights thinking.

Knowledgeable use of legal rules translated into practice

A knowledgeable use of legal rules was highlighted in theme 1, 'understanding the referral situation', as a strategy whereby AMHPs anchored themselves to the letter of the law to weather the organisational challenges encountered, for example in the poor timing of referrals made. Theme 1 addresses a clear tension encountered by participants between adhering to timescales, on the one hand, and on the other the legality and legitimacy of consulting and undertaking the assessment in a way that adheres to the promotion of the persons' rights, such as consultation with their nearest relative. The participants described anchoring themselves to the statutory requirements to buffer against or rebut organizational challenges, for example not feeling the need to compromise or cut corners in consulting with a nearest relative when a section 2 was about to expire, despite the pressure they experienced because of referrals that were poorly timed. The story Participant 3 provided in the findings under theme 1 illustrates further evidence of AMHPs anchoring themselves to the statutory criteria to weather the organisational challenges. Participant 3 was concerned with doing things right in terms of what he considered to be using the law in the right way, in this case within the provision of s11 MHA; the priority for the AMHP was to use the law in accordance with the requirements as opposed to buckling under the organisational pressure to sidestep or take short cuts with the consultation and informing of the nearest relative.

The five themes outlined in chapter 5 highlight that the AMHPs used the law in accordance with a strong sense of doing things right and demonstrate their proficient knowledge of legal rules. This reinforces previous literature that indicates a strong engagement with mental health law by Approved Social Workers (Braye and Preston-Shoot 2005; Preston-Shoot and McKimm 2012; Hatfield 2008; Johns 2004; Peay 2003) and is congruent with the finding that technical knowledge of the law dominates the social work curriculum, with a focus on the legal frameworks for state-led activity (Braye and Preston-Shoot 2006a).

The MHA provides clear channels influencing and shaping practice. This is exemplified by the case story of Participant 9 where the relationship between the three pillars of legal literacy demonstrates a meshing of knowledge of legal rules with the interface between law and values. The participant here demonstrates knowledgeable use of legal rules; for example, her case story reveals the importance of identifying the nearest relative under the provisions of section 26 MHA, informing and consulting with the nearest relative under the provisions of section 11 and considering the cases referred to them and interviewing the person in suitable manner required by section 13 MHA. However, this combined with a disposition towards wanting to do the right thing by supporting the nearest relative and wanting to intervene to improve the quality of life of the person.

Law's interface with values translated into practice

The findings of the study illuminate the interface between law and values and how this translates into practice. The interface of law with values, the ability to use the law to do right things, was closely related to a confident awareness and knowledge of the legal rules, examples of which are outlined above.

A further example of this comes in the case story of Participant 5, who described an assessment on a medical ward where there was pressure placed on the person to be transferred to a psychiatric ward. This was contrary to what the AMHP considered the right thing in the circumstances, believing that the person needed to continue to receive nursing care on a medical ward in conjunction with assessment and treatment for mental disorder. The AMHP made an application for section 2 MHA in this case, in accordance with legal rules that an application under the MHA needs to be made to a hospital, which can include a general hospital if there is a need for assessment and treatment for a mental disorder in conjunction with a need for treatment for physical health issues. The interface of mental health law with values arises where the AMHP advocates for the wishes of the person assessed to remain on a general ward where she is described as still having a catheter and a drip. This is further

linked to the interface with values in the acknowledgement by the AMHP, working together in alliance with the independent s12 doctor and the relevant bed manager for the psychiatric bed, that whilst the person meets the legal criteria for s2 MHA they would not have their needs met adequately in the psychiatric ward. This was based on the AMHP's experience of that ward; for example, he knows that they don't have hoists to bathe people and that this would make things difficult for the person assessed. The AMHP was also aware that the person was in physical pain and had a medical mattress that enabled her to be comfortable, noting that the psychiatric ward does not have such beds. A strong and confident knowledge of legal rules therefore meshes with the interface of values, with the AMHP orchestrating not only the application for s2 MHA, but additionally for this to take place in a suitable ward environment, which was motivated by a desire to do the right thing in addition to doing things right. The following extract from the case story illustrates the point:

'We decided in the end that we would put her on a section, and I think she was kind of agreeing with us, but with the view that she stayed at (name of the general hospital) so that she could get the right level of care. She needed to really be on a physical health ward for mental health. However, the physical health ward was insistent that she went over to the (name of psychiatric hospital ward). I know that the elderly ward at (name of the psychiatric hospital) would really struggle with her, she had a catheter and she was on a drip, the issues of trying to get her bathed would be very difficult because they don't have that hoisting system, and they certainly don't have these beds. So, I was really concerned about the pressure that was being put on us to take her to the (name of psychiatric hospital). The Section 12 doctor helped because he said that he won't do a medical

recommendation if she goes to the (name of psychiatric hospital). So I was grateful for that as well. Obviously, I was the one that had to make the decision. I had to do some micro-managing'.

(Participant 5).

This account adds contextual depth to the findings of Peay (2003) who found that where there is a difference between the opinion of AMHPs and a doctor then the AMHP normally 'wins' in these confrontations. My findings extend the understanding here, highlighting that this is nuanced. An alliance was formed between the AMHP and one of the doctors, showing that opposition does not always arise in the form of AMHP versus doctor, as this case illustrates that the confrontation and different views involved AMHP and doctor versus doctor. This emphasises that the autonomy and independence of the AMHP not only relates to the binary between detainable or not detainable, in contrast to Morgan et al (1999), but also relates to how the law is used, emphasising the importance of process, which includes the interface of values and the law. The outcome in this case was an application for s2 MHA, which on the face of it suggests that everyone agreed, but the agreement also involved the AMHP challenging the medical discourses of a consultant psychiatrist and consultant physician, providing further illumination to the findings of O'Hare et al 2013 who found that mental health social workers' over familiarity with medical terms may be linked to questioning their ability to challenge medical discourses. The example from the findings illustrates that there can be familiarity and acceptance with medical terms such as diagnosis whilst retaining an ability to challenge medical discourses.

A further example of the interface with law and values is found in the entire case story provided by Participant 9 who, while following the provisions of the MHA to identify and consult with a nearest relative by using her knowledge of legal rules, went further, highlighting that there was an intentional motivation to also do the right thing by using the opportunity to speak with the nearest relative in person to provide support, and describes providing her with somewhere to 'vent', reflecting that in her experience when consulting with

nearest relatives she hears a lot about their stresses. The AMHP describes that she understands the legal requirement to consult with the nearest relative but implies that the process requires more than adherence to legal rules: 'I think it is a bit more than that. I think it is about hearing what they have to say' emphasising that they are "very important people'.

Translating human rights into practice action

Whilst the first two pillars of legal literacy were embedded in the data of the entire case stories, the third pillar - action by reference to human rights, or rights thinking - was less explicit. This third pillar is arguably the weakest of the three that underpin legal literacy in the social work AMHP practice described in this study. The literature provides context for this, revealing the shape of the unstable ground beneath this pillar, highlighting that lack of emphasis on rights thinking might be located, in the context of the social work law curriculum, which rarely assesses the understanding of human rights frameworks, anti-discriminatory legislation or levels of critical analysis (Braye and Preston-Shoot 2006b). This unstable human rights foundation resonates with Campbell's (2010) proposition that whilst social workers ought to be equipped to recognise and challenge the way that mental health law discriminates against disadvantaged groups in society, such a knowledge base is less articulated in practice.

The data in the case stories are focused on the individual referred, the situation causing concern and the views of others in relation to this. The emphasis is placed on individual deficit in terms of the person's mental state and need for psychiatric care in the form of assessment and or treatment. In all the case stories the four walls and locked doors of a hospital were the favoured option where a lack of feasible and available alternatives predominated. Participants took a deficit and needs approach to use the law where their knowledge of legal rules was combined with the interface of law and values; they did things right in terms of their use of the law and extended this to a clear motivation to do right things. However, there was less attention paid to the potential to use the MHA, or by reference to acting as a public authority under the Human

Rights Act 1998, to expressly promote the individual rights of the people that they assessed. However, this is not a simple equation. It could also be argued that they promoted the rights of the person to receive psychiatric care, or that a rights perspective was used relationally, meaning that they privileged the rights of carers and family. The findings do highlight an emphasis on the person receiving psychiatric care, and that the rights of others close to the person assessed are privileged over the rights of the person assessed, mainly due to a lack of dialogue associated with the person assessed experiencing a disturbed mental state and the significant risks posed to others. Intervening based on deficit and need may produce a subsequent improvement on the ability of families to coexist, thereby promoting the right to respect for private and family life, as provided by the European Convention on Human Rights (article 8), in the longer term. However, the fundamental right to individual liberty (as provided under article 5), whilst not unlawfully breached by proper use of the MHA, is not necessarily promoted in the accounts of participants about how they use the law in practice. This is congruent with the literature on the relationship between law and social work, which proposes there is less attention to the potential for law to promote service users' rights and empowerment, or ways in which the law might lead social work to engage in collective action, in comparison with the fundamental emphasis on individual problem-solving approaches to professional intervention (Braye and Preston Shoot 2006).

At both a local and international level the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) provides both a challenge and an opportunity for social work AMHPs to both face up to the coercive nature of their role, as proposed by Campbell (2010), and strengthen the third pillar of legal literacy - to pay more attention to engaging in collective action and orient their use of law to practice by reference to human rights (Braye and Preston-Shoot 2006b; Preston-Shoot and McKimm 2012).

I now discuss the organisational factors impinging on the potential for participants to orient their action by reference to human rights, drawing on Lipsky's (1980) street level bureaucracy, and in particular his concepts of the

social construction of a client, and patterns of practice (outlined in chapter 3). The concept of 'the social construction of a client' refers to the exercise of control over clients that in turn affects the construction of a client, while 'patterns of practice' refers to how people simplify complexity by creating routines to make tasks more manageable. These theoretical concepts are used to illustrate the central premise of street level bureaucracy applied to the findings: that AMHPs cannot do the job according to ideal conceptions of practice because of the limitations of the work structure. The ideal conceptions of practice referred to here are those related to the potential for AMHPs to orientate action with more explicit reference to human rights when using the law.

The concept of the social construction of a client is relevant to how participants described using the law because the assessments required them to exercise some form of control over the client in terms of where and when they were assessed, for example using a section 135 MHA warrant to assess someone in their home against their wishes. Of course, this control exercised over the person assessed is in the context of the game already being in play when the referral is received, as outlined in the argument (above) that AMHPs' use of the law involves a temporality of practice. The referrals were all accompanied by a sense that 'something' needs to be done and the transformation of troubles into problems that require a MHA assessment had already taken place. This then links with the concept of patterns of practice where the habitus of the AMHP, or how they embody the law (outlined above) is oriented to containing the problem and the risks. Therefore, the ideal conceptions of practice envisaged by action oriented to human rights are limited by the work structure that involves a particularly harsh climate of practice where the space to orient to human rights focused on the rights of the individual assessed is limited.

A nuanced coercion over autonomy

The tension between coercion and autonomy was implied throughout the case stories outlined in the findings chapter, which focused on using the law to compulsorily admit people to hospital against their will; here there was a clear

implied tension between protection and coercion on the one hand and autonomy on the other. This tension manifested most notably in the findings organised under theme 4, 'community versus containment'. This theme emphasises the focus of the AMHP on the feasibility of the person being in the community, hospital as a place for plans to be put in place, trust, medication in the community, ability of family to cope, and finally the feasibility and availability of community support options.

Participants normally opted for coercion in the form of the protection - to the person assessed and others - offered by detention under either section 2 or section 3 MHA. This led to the four walls and locked door of hospital as a place where plans could be put in place. This was, at-least in the short term, preferred to enhancing or promoting the autonomy of the person assessed by opting for less restrictive and coercive community based interventions. This is because participants did not think the community could contain the situation causing concern and because of the feasibility and availability of community support options. The findings reveal that in practice there was a preference to privilege protection and coercion over autonomy largely due to the intractable barriers to dialogue experienced by AMHPs in the context of high levels of mental distress observed in the people they assessed. Notwithstanding this, the nuanced and complex relationship between coercion and autonomy emerges in the findings where participants clearly acknowledged that opting for coercion in the form of compulsory admission to hospital has undesirable consequences, notably the imposition of the loss of liberty of the person assessed.

Mackay (2011) makes an interesting point about the somewhat dichotomous notions of coercion and autonomy, pointing out that the strength of dichotomies lies in presenting a standpoint to base an argument, but that they do not always help to explore the middle ground. An important point about the middle ground that resonates with the findings is that 'occupying the middle ground as a phrase holds out visions of comfort far removed from the daily lives of most practitioners' (Braye and Preston Shoot 1990: 335). The findings show that there was no such vision of comfort for AMHPs, who struggled to form a

judgment about the community as a space where the situation could be contained. This judgment was based on the view that there was a need for immediate containment to enable planning, and that without this containment plans cannot move forward; these are plans that focus on stabilizing things and returning some sort of equilibrium in the future. The nature of these plans focuses on enabling supervision in the community, consideration of the person receiving medication in the community, ability to involve the person assessed in these plans, and the ability of family or carers to cope. Here, a deeper understanding of the findings arises in the acknowledgement that these plans are in fact aimed at promoting greater autonomy in the longer term as a more desirable outcome for the person assessed than coercion and protection. In this way, whilst protection was privileged over autonomy by the AMHPs it was nuanced to enable autonomy to be sustained in the longer term. Thus, coercion is also closely linked to promoting autonomy, although there is undeniably a tendency for coercion as a response to acute mental distress and the impact that this distress was perceived to have on those close to the person and the wider community. In this way, the AMHPs are oriented towards care ethics as a perspective, akin to the 'compassionate interference' in autonomy proposed by Verkerk (1999), 'not as a threat to autonomy but as a way of attaining autonomy' (Verkerk 1999: 354). Thus, the findings provide further recognition to the call by Campbell (2010) for AMHPS to face up to the coercive nature of their role whilst also acknowledging that there is a need for 'more nuanced and less dichotomous interpretations of the moral imperatives for autonomy and protection' (Braye, Orr, and Preston-Shoot (2017: 9).

4. A socio-medical-juridical perspective

I now outline my argument that AMHPs' use of the law in practice involves a wide social perspective that provides depth to a medical perspective. It is a wide social perspective because it is mainly concerned with looking beyond the person assessed, to consider the social consequences experienced by others who have a relationship to the person who is being assessed under the MHA.

The existence of a wide social perspective in the findings does not however, completely extinguish concerns that the social perspective of AMHPs is subsumed by medical perspectives (Campbell 2010; O'Hare et al 2013). Social causation and social perspectives informed by recovery and rights based perspectives are not emphasised by participants, in part because of the environment of practice. Social work AMHPs appear to have the knowledge to promote this sort of social perspective when asked to consider case vignettes (Peay 2003; Colombo, et al 2003; O'Hare, et al 2003) but do not appear able to live up to the idealised conception of their role when making decisions in practice (Lipsky 1980).

This wide social perspective includes perspectives on process not just perspectives on pathology or other characteristics of the person assessed. This is however, a weakness in the sort of social perspective that participants describe in the findings. This may be associated with a lack of clarity about what a social perspective means for mental health social workers AMHPs (Tew 2011). A key point here is that for AMHPs the social perspective is important in terms of how they use the law; I do not wish to minimise the significance of this. However, I argue that the way that they occupy the social perspective in the findings is wider and more multi-layered way than previously acknowledged in the literature, which has highlighted social perspectives as subsumed by medical perspectives (Campbell 2010; O'Hare et al 2013), or as representing a win or lose situation where one perspective dominates the other (Peay 2003). The social and medical are not necessarily separated, and different perspectives don't always equate with different decisions. Social and medical perspectives of participants are multi-layered, with more than one frame applying at the same time, existing within relationships of interdependency (Goffman 1974). Medical evidence that someone is suffering from a mental disorder of a nature of degree that warrants their detention in hospital could be viewed as a social process which in many of the assessments described by participants involved a social crisis in someone's life associated with a mental disorder. The struggle for a social perspective outlined in the literature review in chapter 2 has traces of this structured dichotomy between social and medical perspectives.

The tension between medical and social perspectives in mental health care manifests long running debates about fundamental points of philosophy and practice, involving a shift from a medical model of mental health problems to a social model perspective (Clark 2015). This debate between the medical and the social runs the risk of over-emphasising the distinction between the two. Indeed, it is likely that numerous perspectives are involved when using the law in mental health social work. This can be seen in research by Colombo et al (2003), whose large-scale qualitative study about the influence of implicit models of mental disorder on shared decision making within community mental health teams found that Approved Social Workers implicitly supported 10 of 12 elements within the social model and 8 within the psychotherapeutic approach. The study reports that social workers showed little direct support for medical treatment and were likely to focus on the social rights of patients.

Evidence of how a multi-layered perspective works in the findings comes in under the theme of 'relationships and resources' (theme 5), highlighting how the AMHP's autonomy and independence are both important to participants, illuminating that AMHPs agreeing on the outcome with doctors doesn't mean that autonomy and independence are not used during the assessment. Congruent with a wide social perspective, autonomy is used more overtly in relation to *process* as opposed to the *outcome* of assessments described by participants. Autonomy was experienced as a resource potentially to enable taking the opposite view to medical colleagues involved in the MHA assessment but also as a resource to potentially to share the same view about a person as the medical colleagues involved (see above under legal literacy and social work AMHP practice where this is expanded on in relation to the interface between knowledge of legal rules and values).

Under the theme of 'understanding the individual' (theme 2), participants describe trying to understand the individual referred to them. This involves a wide social perspective that provides depth to the medical perspective of the doctor(s) who undertakes a medical examination of the person referred. The wide social perspective used takes into consideration social factors as part of

the overall process of understanding the individual and the situation causing concern and takes place before, during, and after the medical examination. For example, Participant 9 detains the person based on two medical recommendations, which provide a medical view of the person. However, the important thing for this participant is not the diagnosis, apart from making it clear that the man has a diagnosis of schizophrenia, which highlights a somewhat psycho-centric social perspective. However, it is not the illness or medical perspective that she talks about in any depth, it is the impact of the medically diagnosed illness and symptoms on the family, and how this causes the person not to be able to function as well socially as they would if they were 'well'. Here we can see that there is a medical perspective in terms of the acceptance of mental disorder (required for s1 MHA), but it is how this impacts on the person, and their family that matters to the AMHP (criteria for s2 and s3 MHA are also implicated here). This is an example of a social perspective providing depth to medical evidence.

The findings provide evidence for my argument illustrating that the social perspective is not only focused on medical evidence. The social perspective highlighted in the findings under the themes of 'understanding the individual' (theme 2) and 'understanding the situation causing concern' (theme 3) includes interpreting historical events, unusual beliefs and behavior, the participation of the person assessed when interviewed face to face, and contradictions in understanding between the views of the person being assessed and those of others. The factors that appeared most significant for participants, when taking into consideration these different social perspectives, involved the person's social and family situation. An example of how this works comes in theme 1 where all the participants interviewed recounted that receiving the referral was accompanied by something serious in the recent past that framed the current concern about the person. The serious incident was often the trigger for the referral, and whilst this was invariably linked to the person assessed experiencing a disturbed mental state, the focus for participants was on the social crisis. For example, the AMHP who assessed a woman in hospital who had jumped out of a moving car as her family drove her to A&E focused on the inability of the family to cope and the difficulties for the person functioning in the

community, being unable to care for herself and at risk of harming herself. Further evidence of the wide social perspective in theme 2 comes in where the AMHP searched for an understanding of the individual to interpret whether an argument could be made that the legal grounds for detention were met and if so whether an application for detention ought to be made. This perspective was wide, their understanding reached in part through interpreting the family's understanding. This involved understanding the individual in their environment in relation to others as opposed to a narrow understanding of the individual in isolation from the impact on and from others. A further example of the wide perspective is found in the description of Participant 11 who described an assessment in hospital, which involved interpreting whether an argument could be made that the legal grounds for section 3 MHA were met, and whether they should make this application. The description of this process demonstrates that their understanding is reached in part through interpreting the family's understanding, provided by the family giving a description of the individual in their environment and the impact experienced by family members at that time. The family and the AMHP link these problems to the disturbed mental state of the person, but the medical perspective taken in accepting this did not involve the AMHP lacking a social perspective on the situation.

The face-to-face interviews are an important component in the assessment. However, the AMHP participants undertook a much wider assessment, which involved calibrating the collateral information, comprising of different stakeholder views, with their own impressions of the person during a face to face meeting with the person at the centre of the MHA assessment. The findings illustrate that most participants described the choice of whether to make an application for detention as a choice between an application for detention or an undesirable outcome occurring at a future date, as opposed to a systematic and rational choice based on a social perspective on medical evidence where the ramifications of such a decision are neutral, for example when Participant 9 described how the person's violence and aggression towards family members made it impossible to contemplate leaving him in the community. This highlights how in participants' stories the choice to make an application was to some extent 'Hobson's choice' for the assessments that they

chose to talk about. The main currency in this 'choice' is perceptions of seriousness of risk oriented to future time.

Further evidence that the medical and the social are not necessarily separated is found in the findings chapter under the theme of 'relationships and resources' (theme 5) where participants spoke about their choice of independent s12 doctor. Normally (with some very specific exceptions relating to assessing Members of Parliament under the MHA where both doctors *must* be s12 approved) at least one of the doctors involved in the assessment needs to be approved under s12 MHA and must be independent of the doctor making the first medical recommendation. In practice AMHPs have a small pool of independent s12 doctors who are used, for a fee, to undertake this role. There is a requirement in some circumstances for the independent doctor to have expertise to match the needs and characteristics of the person assessed, for example children and young people and people with learning disabilities. However, there is also evidence in the findings that all the AMHP participants chose the independent s12 doctor to use based upon their working relationship with that doctor where mutual respect was a valued currency. In addition to the currency of mutual respect one also spoke of choosing a s12 doctor that '*doesn't mind being a bit bolshie*'. This Participant described the s12 doctor and the AMHP combining perspectives to counter the perspective of the doctor making the first medical recommendation in relation to the *process* of assessment as opposed to the outcome of the *decision*.

Evidence to support my argument that a social perspective permeates the entire process of using the law and involves social factors such as trust/distrust that are not highlighted in the literature is also found under the theme of 'community versus containment' (theme 4) where trust as an important concept operated at several different intersections in the juxtaposition of community and containment. This involved interpersonal trust (trust in people) and systems trust (trust in more abstract systems/institutions). Where participants spoke about the notion of community versus containment there was lack of trust in the hospital where the person was detained as an institution. However, this was nuanced with higher trust apparent when participants spoke about their local

acute admissions ward. A paradox exists here in the apparent lack of trust in the person assessed to be able to leave hospital, as interpersonal trust operates in relation to whether the person assessed can be trusted to engage with mental health services in the community and be trusted per se to being in the community. Distrust in the person to be in the community because of the perceived need to do something to contain the situation results in preference for containment of the person, and indeed the situation causing concern, which occurs in the paradoxical state where there is distrust in the institution that is proposed as offering the most preferable solution.

The perspective of the AMHP when using the law in practice involves a socio-medical-juridical model. This model includes the AMHP taking a wide social perspective during the assessment process, involving consideration of social factors, which are highly influential on decisions to detain. The term 'medical' is included to acknowledge that a medical perspective is employed by AMHPs; however, in this model this does not involve comfort with medical discourses equating to an inability to challenge these discourses. A juridical perspective captures the embodied practice of using the law that, in addition to the reference to legal clauses, also involves dispositions that generate habits and practices where the conditions of the field impact on how law is used. The link between knowledge of legal rules and the interface of these rules with values and orienting action to human rights (Braye and Preston-Shoot 2006b; Preston-Shoot and McKimm 2012) represent three pillars of legal literacy encompassed in the term juridical used here. The juridical field that the AMHPs inhabit is the dynamic that drives their approach to the medical and the social; the juridical acts as a bridge mediating them. Within the MHA, the key provision that unlocks this dynamic is found in the requirement for the AMHP to consider whether detention in hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment that the person assessed needs (see section 13(2) MHA).

My findings partially reinforce those of Quirk et al (2000) and Fistein et al (2016) that availability of alternatives to in-patient care is an influential factor in relation to whether an AMHP decides to make an application to detain the

person. The impact on others and consideration of proximity of harm as influential are partially congruent with Fistein et al (2016) in their finding that 'risk assessment' is an influential factor in relation to how the law is used. As outlined below my findings reveal nuance and complexity associated with how risks are assessed and managed that is further reinforced by O'Hare et al (2013) in their finding that more holistic narratives emerged when their participants considered how risks could be *managed* in comparison with their findings that medical discourses were relied on in the *identification* of risks.

O'Hare et al's (2013) finding that in the case of English AMHPs there were few concerns raised by them about the interface between the mental capacity and mental health legislation is reinforced in my findings that this interface posed few problems for my participants who used the law at the interface of the MHA and Mental Capacity Act 2005 (MCA).

My findings also partially contrast with Peay (2003) who highlights that the ASWs involved in her study took a distinctive social perspective in contrast to the medically dominated perspective of psychiatrists when considering case vignettes, and the net result of that different perspective is revealed below as operating in a different way in my findings from that proposed by Peay (2003) as a win/lose result.

In contrast to Fistein et al (2016) and O'Hare et al (2013), the findings did not reveal that a psychiatric diagnosis, and likelihood of responding to treatment, was an influential factor in participants' descriptions of factors relevant to their decisions to detain. My own findings reveal a social perspective and understanding where 'unusual beliefs and behaviour' are influential in decisions to detain when behaviour associated with them impacts on others. The need for medical treatment was not the main pre-occupation, although it was a factor in decisions to detain. However, a prominent social factor associated with the justification to detain the person was the rationale of 'plans needing to be put in place' to enable better discharge arrangements. The findings on the socio-medical-judicial model also provide an interesting contrast with O'Hare et al's (2013) findings, which suggest social work participants were over-familiar with

medical language, appearing to be comfortable using terms such as “command hallucinations”, “delusional thoughts”, “psychosis”, “paranoia” and “psychotic episodes”. These findings were placed in the context of raising questions about the ability of social workers to challenge medical discourses that the authors proposed as tending to dominate mental health services. My findings provide some reassurance that a holistic and social perspective dominated by social discourses is alive within the voices of participants in my research where medical concepts are extended and provided with further depth, nuance and complexity. Different perspectives between social workers and medical practitioners should not however be conflated with arriving at different decisions, as my findings suggest most decisions resulted in the person being detained under the MHA. In other words, the doctors and AMHPs agreed, albeit that it is likely, (contra Fistein (2016), Peay (2003) and Quirk (2000)), that they agreed based on contrasting perspectives. My findings differ with Peay (2003) here in that taking a different perspective is not a ‘win’ or ‘lose’ game played out between the doctors and AMHP. Further difference with O’Hare et al’s (2013) findings that there may be a lack of clarity about how risk is assessed and ambiguity about the thresholds for compulsory intervention is revealed in my findings where there was a lack of ambiguity about thresholds for compulsory intervention, with participants who appeared to have strong knowledge and experience of the application of legal rules and a feel for the game. The evidence revealed in my study that social work AMHPs take a wide social perspective that provides more nuance and depth to medical perspectives is further contrasted with Barnes, Bowl and Fisher (1990) who voiced concern arising from their research findings that social services staff tended to defer to psychiatric explanations and responses.

My findings are in further contrast to Fistein (2016) in that the degree of difficulty in the decision was not an influential factor for my participants whose descriptions of complex, often fraught assessments were notable by the absence of any apparent difficulty in decision-making, with participants appearing to use the law like fishes in water. The proposition of Fistein et al (2016) that ‘risk assessment’ is an influential factor is extended in my own findings by revealing that risk was considered by participants more holistically,

in common with O' Hare, et al (2013). The finding by Peay (2003) that participants took a cautious approach in relation to risk that impelled a decision to do something rather than 'let a situation develop' without the use of compulsion is further extended with the findings, where not doing something and 'leaving the situation to develop' would be unthinkable in many cases given the types of harm that they were asked to do something about. Consideration of harm also includes the influential consideration of the views of others such as family or carers and the ability of family to cope with the person assessed. Further contrast is provided in the analysis of my findings, which highlight trust as an important concept that is not illuminated in any of the literature.

The finding that meaningful dialogue and ability to establish at least some rapport with the person assessed are important factors impacting on the use of law in practice reveals further depth to the finding by Fistein et al (2016) that the capacity of the person assessed to make decisions about treatment is an influential factor on decision-making under the MHA. My findings further extend those of Morgan (1999), where making decisions under the MHA was perceived in dichotomous terms as 'sectionable' or 'not sectionable', whereas my own findings reveal and extend knowledge of the factors that are associated with decisions to detain, which also enables the process of using the law to be illuminated as opposed to framing the law in practice associated with dichotomous 'decisions'.

5. Conclusion

This chapter has provided a discussion of the research findings, using the research questions as a reference point throughout. The discussion was in three main parts. In the first of these I set out the argument that social work AMHPs' use of the law involves an embodied practice, drawing on Bourdieu's (1977) practice theory, highlighting the importance of dispositions in generating habits and practices, and the significance of the temporality of practice. Ewick and Sibley's (1998; 2005) legal consciousness theory was utilised to highlight the legal wind-chill factor that impacts on how social work AMHPs relate to the law. In the second part of this chapter I used the concept of legal literacy for

social work AMHP practice (Braye and Preston-Shoot 2006b; Preston-Shoot and McKimm 2012) to conceptualise and organise a discussion of the findings that illuminate knowledge of legal rules, the interface between law and values, and translating human rights into practice action (Preston-Shoot and McKimm 2012). In doing so the pillar of legal literacy relating to translating human rights into practice action was identified as the weakest. Possible organisational factors impinging on promoting a human rights perspective were proposed, drawing on Lipsky's (1980) street level bureaucracy. Further discussion of tensions between autonomy and coercion were discussed in the context of human rights perspectives, highlighting a nuanced protection over autonomy by participants. The final part of the discussion chapter argued that the perspective of AMHPs when they use the law in practice can be represented by a socio-medical-juridical model. The essence of this illuminates how the AMHP is driven by the powerful juridical field, which acts as a bridge mediating medical and social perspectives.

Chapter 7: Conclusion

1. Introduction

This chapter provides a conclusion to the research study by looking back on the steps of the argument, emphasising the key messages and contribution of the thesis, and critically evaluating of the research approach. The conclusion is structured in two parts. The first looks back to the research problem and purpose of the study, and highlights the key findings. The second part looks forward to the implications for practice and research.

2. The study purpose and rationale

The research study focused on how social work Approved Mental Health Professionals (AMHPs) use the law in practice. AMHPs in England and Wales have statutory powers under the Mental Health Act 1983 (MHA) to detain people in hospital for assessment and/or treatment. In England and Wales social workers are, due to the historical role played previously by ASWs, the lead profession undertaking this role. The stakes in this area of law and social work are high: practitioners deal with important issues concerning individual liberty that have profound implications in relation to the power of the state to intervene in the lives of citizens, where notions of autonomy, protection, coercion and care sit in tension.

The study explored the relationship between law and social work AMHP practice by interpreting meanings contained in case stories told by social work AMHPs about recent MHA assessments that they undertook. The study addressed the previous calls for an exploration of how legal literacy translates into practice (Braye, Preston-Shoot and Wigley 2011; Preston-Shoot and McKimm 2012), and in doing so undertook an analysis of the of interplay between law and social work to articulate the complexity of the task of using

the law in practice (Braye and Preston-Shoot 1990). The research study also responded to Campbell's (2006) call for more research about the mental health social work role, and took account of Campbell's (2010) proposition that in critically understanding how they are positioned across complex legal, organisational and human systems, mental health social workers may be better prepared to work with the ambiguities of the role and to resolve the tension between the requirement to coerce legally, whilst also striving to protect human rights. The study addressed the call for a far more searching analysis of the interplay between law and social work (Braye and Preston-Shoot 1990: 334). Its findings resonate with a need for 'more nuanced and less dichotomous interpretations of the moral imperatives for autonomy and protection' (Braye, Orr, and Preston-Shoot (2017: 9).

The problem that the study addressed was the gap in knowledge emerging from the literature review, which found a lack of emphasis on the entire process of using the MHA in practice when carrying out a MHA assessment, from the point of receiving a referral and arriving at an understanding of it with a wide range of people involved. The literature places major emphasis on the 'assessment' under the MHA as a site where 'decisions' are made and located. This does not address the socio-relational nature of using the law in practice across the whole process of referral and the search for understanding, and therefore relationships and interactions with people-such as other professionals, the person assessed, and family members-missing from the literature; the socio-relational aspect of using the law in practice is therefore not captured by the literature. The literature review revealed gaps in knowledge about how social work AMHPs use the law in practice. The hermeneutic phenomenology of using the law in practice by AMHPs is not well understood; instead decision-making from a standpoint of a difference between policy and practice is the major area of focus.

The use of a social and medical lens by AMHPs when they use the law in practice is not well understood and there are debates about the extent to which this is possible. These concepts tend to place the medical and the social at odds with each other and there is a need to reconceptualise these standpoints

to capture the complex and nuanced nature of using the law in practice (Braye, Preston-Shoot and Wigley 2011), which includes a need to answer the call for mental health social work to reconceptualise and face up to the coercive nature of the role (Campbell 2010).

2.2 Review of study design

Methods

Interviews were the main method of data collection used. A limitation of interviews is in relation to the disjunction between what humans do and what they say that they do. However, the purpose of my research as stated is to focus on the representations of AMHPs in relation to how they use the law in practice. Acknowledging that the focus is on representations takes account of the fact that 'all forms of representation of experience are limited portraits' reminding us that we are 'interpreting and creating texts at every juncture' and that 'our narratives of others' narratives are our worldly creations' Reissman (1993:15). The interviews worked in providing rich data; my role as an insider enabled participants to speak openly and in detail. The ontological stance underpinning my research is characterized as social constructionist, whereby the socially created nature of social life is emphasised, acknowledging that society is actively created by human beings (Berger and Luckman 1966). My epistemological stance is based on the belief that human action is given meaning through interpretation and researchers have to make sense of how people make sense of the world' (Orme and Shemmings 2010: 88).

Practitioner diaries were used as an adjunct method of data collection. There are clear limitations with the execution of this method in the study that have been transparently represented in the methodology at chapter 4. I tried it, it didn't work out as well as I hoped, but I learnt from it and consider that as an adjunct method of data collection in the overall design of the research project the way that it worked out does not adversely impact on my findings as they are not dependent on the diary method. Despite their potential, diaries are not widely used as a method in research. Willig (2008) suggests that this is

because the method constitutes a challenge for both researcher and participants. This proved to be the case in the research study and enabled valuable lessons to be learnt, which I intend to apply to planned post-doctoral research: firstly, the requirement for the diary to form a central plank of the research as opposed to an adjunct role, and secondly that ongoing relationships with participants are key to enabling the success of a diary as a method of data collection. The Diary-Interview method (Zimmerman and Wider 1977), where the diary is the focus of data collection and interviews provide a structure for the diary research, has potential to enhance the utility of this method.

2.3 Review of key findings

The study illuminates that using the law in practice is an inherently socio-relational undertaking. AMHP practice is patterned and structured but not explained solely as drawing explicitly on knowledge of legal rules contained in the MHA and related guidance. Its socio-relational nature encompasses three elements: firstly, the implication of different parties involved possessing varying degrees of status bestowed by titles, professional qualifications, and classifications: doctor, patient, AMHP, carer; secondly, the dynamic juridical field where the law is used, is a field of constitutive power, the power to name: one person is detainable under the MHA while another person is not; and finally, the concept of habitus, which recognises the importance of habits, dispositions and perceptions as guides to human action. The study findings suggest that AMHPs' perspectives are holistic and social and can be understood as occupying a socio-medical-juridical perspective. The most important factor in the decision to use compulsory powers in mental health law to detain a person involves the AMHP taking a wide perspective in terms of their understanding of the individual that is relational to the understanding of others, and understanding the person in their environment in relation to how they relate to others. The thesis outlines that 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. This leads to the further argument that a holistic and social perspective does

not necessarily lead to less coercive interventions. Medical and social perspectives thus often lead to the same conclusions in relation to decisions to use the law to detain. In addition to availability of alternatives to detaining the person, the feasibility of community support options is also an important factor in deciding to detain.

Five themes were presented in the findings chapter: understanding the referral situation; understanding the individual; understanding the situation causing concern; community versus containment, and relationships and resources. Taken together these create a picture of a complex and holistic process in which the dynamics of the situation were explored in the context of wider service and community level features.

AMHPs were initially engaged in the work of finding a bearing on the referral situation in the context of an adversarial atmosphere and organisational factors, such as poor timing of referrals and difficulties experienced by a lack of local psychiatric beds. This was referred to as the legal wind-chill factor accompanying the referral. The temporality of practice was emphasised under the first theme where the game was already in play, even before the referral was received by an AMHP. Troubles emerge as problems and notions of risk are conjured together with more concrete descriptions of the nature of the risks. The referral situation often involved a rupture in the relationship between mental health services and the person referred.

The second theme captured the work of understanding the individual. The relational nature of this process was a consistent finding: AMHPs gained an understanding of the individual by interpreting other people's understandings of him or her. AMHPs combined background information about the person with their own impressions during the face-to-face interview with the person. This involved interpreting troubles and problems, which highlighted contradictions in understanding from the perspective of the person referred and involved opposing views to their family and, often, mental health services. The most influential factor on decisions to detain was the role of the social and family situation of the person referred.

The third theme dealt with the work of the AMHP understanding the situation causing concern, where attention is focused on perspectives of risk on the community, where risks to family and others, and risk to the health and safety of the person referred, are pieced together. The views of family members or carers on what needs to be done occupied an important and influential space here.

The fourth theme of 'community versus containment' reveals that a key question for AMHPs is whether it is feasible for the person to be in the community. The containment provided by a hospital ward was considered preferable as a place where plans could be put in place. This involved a complex trust dynamic where there was both a lack of trust in the hospital as an institution, and a lack of trust in the person to leave hospital. When thinking about the community as a space for the person referred there was a focus on the feasibility of the person taking medication in the community together with consideration of the ability of family to cope. Less restrictive options to detention under the MHA were considered in relation to both their availability and their feasibility.

The final theme of 'relationships and resources' highlighted that using the law in practice also involves a logistical undertaking where relationships and resources are important factors. This takes the form of inter-professional and inter-agency working relationships. The notion of being autonomous was an important concept for the AMHPs. This was linked to both inter-agency and inter-professional working relationships, and as a resource when using the law in practice. Autonomy was experienced both as a resource to be able to take the opposite view to medical colleagues involved in the MHA assessment and as a resource to share the same view about a person as the medical colleagues involved. Hence AMHPs emphasised their autonomy notwithstanding their agreements with doctors. In other words, the potential to disagree was the important factor. The AMHP relationship with the independent section 12 (MHA) doctor appeared to be an important relationship and resource for the AMHP participants and for most participants appeared a discernibly

significant working relationship in comparison with the NHS Trust doctor who has often already made a medical recommendation. The relationship with the independent s12 approved doctor appears important in two respects: in terms of a best fit with the AMHP and best fit with the clinical needs of the person assessed.

There was a non-dichotomous relationship between the medical and the social, different perspectives also led to the same decision, which usually involved deciding to detain the person assessed.

2.4 Limitations of the study

I focused on the experiences of the AMHP as opposed to other parties involved in a MHA assessment. This is based on the scope of the research question and influenced by my professional background and research interests. The advantages of giving prominence to the experience of the AMHP when using the law conversely gives rise to disadvantages, notably the voice of the person assessed under the MHA is largely absent from my findings. What I found in my study is that the odds are often stacked against the person assessed and that an inability to establish rapport and dialogue appear to be important factors in deciding whether alternatives to admission are attempted. I have also acknowledged in the introduction to the thesis that to be detained under the MHA is to feel the full force of the state. Notwithstanding this modest acknowledgement of the impact on the person assessed, the voice of the service user in terms of their experience of being assessed under the MHA is not directly heard. I should make clear however that whilst this is arguably a limitation of the study, it was deliberately not within its scope. Katsakou and Priebe (2007) explored the experiences of people detained under the MHA in England by reviewing qualitative studies. Their findings highlight that the most important issues for people detained are perceived autonomy and participation in decisions for themselves, their feeling of whether they are being cared for, and their sense of identity. Negative aspects of being detained included restrictions on autonomy and no participation in treatment decisions. Conversely, the study also reports more positive experiences of being

detained, highlighting that hospital was often considered to be a place of safety where some patients retrospectively reported that their involuntary admission could be justified when they do not realise they are ill where coercion is viewed as necessary and unavoidable.

A further limitation of the study lies in the design, which used in-depth interviews and practitioner diaries. I was not there when participants did the MHA assessment they spoke about. Observational methods would have provided an opportunity to triangulate the data obtained with an analysis of what went on during the MHA assessment, albeit that this observation would be subject to researcher interpretation. Future research on this topic might employ research methods that use naturally occurring data, combining conversation analysis with ethnography has the potential to provide further understandings of AMHP decision making. However, the ethical implications of using data from people who are in acute mental distress and may lack mental capacity to consent to research participation makes this sort of research a challenging prospect. The sampling method resulted in 8 male and 4 female participants, this needs to be acknowledged as a limitation of the study design. Accurate data on the gender of AMHPs in England and Wales is not available. Whilst this qualitative study did not seek to be statistically representative, I could have purposively sought an equal number of male and female AMHPs. Warner and Gabe (2008) have highlighted the significance of gender in the context of risk assessment by mental health social workers. They identify that male and female social workers assess risk differently depending on whether they are assessing either male or female service users. Given this difference, an equal number of male and female participants could have enabled my sample to reflect this relevant research knowledge. However, it was not possible to obtain an equal number of male and female participants because I stopped sampling based on recruiting sufficient numbers of participants, as opposed to recruiting equal numbers of both genders. A sample strategy that pays attention to gender will be an important consideration for future research.

My role as an insider-researcher permeated the entire study. I fought against this insider status at times, seduced by the false notion that minimising this

identity would provide my findings with greater credibility. However, in the final analysis, I owned up to the implications of my insider status. Being an insider researcher brought with it both advantages and disadvantages. The temptation to amplify the advantages was sometimes at the expense of minimising the impact of my insider identity on how I dealt with the data. The thesis has my social work AMHP voice echoing throughout. I identified with participants. These factors need to be highlighted as a limitation of the study, albeit that owning up to this also adds credibility to the findings. When interviewing participants, I was struck by their commitment and the sense that they were doing the best they could in difficult circumstances. This gave rise to a feeling that I wanted to represent the voices of my participants in a way that did justice to the difficult role they inhabit. At times this may have led me to interpret the data in a way that was favourable to participants. I found it useful to acknowledge the impact of my insider role on the study. This enabled me to keep a critical eye on how I had represented the data and at times led to a re-examination of how data were interpreted and represented. This led to changes where I found that my interpretation had been too sympathetic to the participant and not critical enough.

Three theoretical lenses comprised a framework to understand the data. Privileging these lenses inevitably facilitates some understandings and forecloses others. Potential difficulties lie in the complexity of combining three theories to comprise a single theoretical framework. This required a detailed consideration of the contribution of each to distinct aspects of the research data. A disadvantage here is that this has the potential to foreclose the potential of each of the different theories to illuminate aspects of the findings where they were not put to work. The theoretical framework brought some advantages in terms of the breadth of micro, meso and macro perspectives it provided. The benefit of breadth may have been at the expense of coherence and depth, which one theoretical lens could have supplied.

Bourdieu's theory of practice (1977; 1987;1990) gave rise to significant understandings on the role of temporality, shedding light on how game is already in play before the AMHP even receive the referral. Further important

insights provided by Bourdieu included the link between the communication difficulties experienced by the person assessed and low degrees of symbolic capital. This has direct implications to AMHP practice, helping to recognise the role communication has in bestowing capital and the ability to influence the decision of the MHA assessment. Further limitations arise because the theories used attach significance to the individual operating within the constraints of varying degrees of structure. Legal consciousness links the talk, interaction and meaning making to legal structures. Street level bureaucracy links the individual actions of agents to organisational constraints. Bourdieu goes even further, defining human action as habitus, which he refers to as patterned and structured without being rational or calculative. What is sometimes less emphasised in these theories is a sense of human agency being privileged above structure to generate understanding of the social world. However, as the focus of the research was how social work AMHPs use the law, it was useful to draw on theories that accounted for the impact of structural factors on individual agency.

3. Looking forward: implications of the research study for AMHP practice and research

3.1 Reconciling tensions between autonomy and coercion

A key practice implication that emerges from the research study is reconciling tensions between autonomy and coercion. The wide social perspective of the AMHP often privileged the voice of others over the voice of the person assessed, which in turn leads to the conclusion that there is a need to reconcile the tension between autonomy and protection by re-balancing the perspectives of other people to give equal prominence to the voice of the person assessed.

Significant implications for both practice and research arise in response to addressing a need to move the emphasis on from social versus medical perspectives to an agenda that actively explores challenges and opportunities for bolstering the social perspectives of mental health social workers/AMHPs with stronger rights-based perspectives to enhance action oriented to human

rights (Braye and Preston-Shoot 2006b; Campbell 2006; Preston-Shoot and McKimm 2012).

3.2 Orienting habits and dispositions toward action based on human rights

Habitus

A key implication of the study highlights the opportunities for social work AMHPs to address the challenges posed by orienting action towards human rights when they use the law in practice. In the study, legal literacy (Braye and Preston-Shoot 2006b; Braye, Preston-Shoot and Wigley 2011; Braye, Preston-Shoot and McKimm 2012) translated into social work AMHP practice with an emphasis on strong and confident knowledge of legal rules. This was closely linked to applying this knowledge to values, characterised by the AMHP going beyond the black letter of the law to use it to do 'right things'. However, as outlined in chapters 5 and 6, the third pillar of legal literacy - action oriented to human rights - was the weakest of the three in that participants were less focused on 'rights thinking' applied to the individual right to liberty of the person assessed. There are of course all sorts of rights involved in the field of using the MHA in practice, and the rights of the person assessed, family and others to be protected from harm was privileged. This speaks directly to the tension between the requirement to coerce, legally, whilst also striving to protect human rights Campbell (2010). A clear implication here is the opportunity to strengthen a human rights perspective on the foundations of the first two pillars of legal literacy: knowledge of the law and the link between this knowledge and values. The principles underpinning the MHA, which emphasise a rights-based approach, are an area of potential focus along with the provisions of the Human Rights Act 1998 (HRA). The UNCRPD represents an important opportunity for an emphasis on human rights and the need for social work AMHPs to start to engage with the challenges posed by the UNCRPD approach to liberty, which emphasises a social model of disability that challenges detention based on mental disorder. However, the study suggests that using the law in social work AMHP practice is not as simple as applying knowledge of legal rules. The embodied practice of using the law in social work

AMHP practice also needs to be recognised as a key implication for orienting dispositions, habits and perceptions of social work AMHPs towards action based on human rights.

The study illuminates how using the law in practice is an inherently socio-relational undertaking. Habitus (Bourdieu 1977) provides an important theoretical understanding, recognising human action as practice, acknowledging that human action is regulated and patterned without strict obedience to external structures such as rational calculation of legal clauses. This raises important questions about how social structure and individual agency can be reconciled and how the outer social and inner self could be shaped by each other with the aim of orienting action to human rights. Changing the habitus of AMHPs to orientate in this way requires addressing its structured and structuring structure.

The structured nature of AMHPs' habitus highlights opportunities to focus on two main areas. Firstly, rights-based approaches could be explored in AMHP education in classroom teaching and learning and during practice placements. Secondly, the experiences of AMHPs applying the law could be diligently observed and supported; the extent to which AMHP supervision emphasises rights-based approaches needs to be understood. The process of undertaking a MHA itself should emphasise the idea of procedural justice in the form of promoting supported decision-making.

Though structured, habitus is also dynamic in the way it influences and shapes human practices; the key implication here is that habitus can change, it is not a fixed entity (Grenfell 2008). The structure of habitus captures the idea that it is formed by 'dispositions that 'generate perceptions, appreciations and practices' (Bourdieu 1990: 53). Disposition and habit is an important component of the habitus of the AMHP because it bridges the relationship between law and social work AMHP practice. The findings highlight that both habit and disposition are important concepts put to work when using the law in practice. Balancing dispositions and habits further towards action oriented to human

rights requires a focus on other key components in practice theory (Bourdieu 1977), namely capital and field.

Capital

A key implication of the findings for practice is how the conditions of practice and the subsequent social construction of a client work against AMHPs placing greater emphasis on a rights-based perspective. The research study supports the argument for a deeper understanding of how AMHPs establish meaningful dialogue and at least some rapport with the person assessed. This is important because this lack of meaningful dialogue appears to be associated with being detained as opposed to less restrictive options being used. The concept of capital (Bourdieu 1977; 1990) is an important consideration here because the ability of the person assessed to engage in dialogue that could be considered by the AMHP as meaningful was normally significantly compromised because of the person experiencing acute mental distress. This was in contrast with the views and perspectives of others, such as family members, whose voice was ultimately privileged above that of the person assessed. Finding ways to enhance the ability of the AMHP to communicate and find meaningful dialogue with a person experiencing acute mental distress, often together with opposition to mental health services, would address the need to increase the capital of the person assessed, which in turn places greater emphasis on the voice of this person during a MHA assessment. Principles of supported decision-making could be a useful conceptual tool for AMHPs to use to achieve this because it would place emphasis on the voice of the person assessed.

Field and adapting to the legal wind-chill factor

Another key implication of the findings for practice is how conditions of the field have an influence on how the law is used. The research highlights that AMHPs did not start the assessment on a blank slate in a benign environment; rather there was a legal wind chill factor. This came in from two fronts. Firstly, the referral was normally preceded and accompanied by an adversarial

environment at a point of rupture in someone's life when their behaviour or beliefs gave rise to concern when noticed by others. This was an environment where family members could no longer cope with the person's behaviour and where the referral was often made by another mental health professional with a desired outcome in mind: detention in hospital. Secondly, the environment encountered is complex and intense, organisational deficits also impact on the landscape, with a rupture in support provided by mental health services underpinning some of the referrals and often deficits in the planning of referrals. The point to make here is that changes in the conditions of the field could enhance the environment in which AMHPs use the law in practice, acknowledging that these conditions can work against AMHPs placing greater emphasis on a rights-based perspective.

Situations such as those referred rarely, if ever, just come out of the blue. Invariably these ruptures that can no longer be tolerated are situated in the context of a development over time. This was also clearly apparent in some of the case stories told by AMHPs who spoke about the build-up of factors that led to a MHA assessment. At the point of referral when the AMHPs carried out a MHA assessment the person assessed was experiencing high levels of mental distress, where the AMHP considered that there were no other options but to detain the person. This raises questions about the resilience of community mental health services to provide and sustain assertive support in the community for people showing signs of mental distress. It also raises further questions about why family members so often felt unable to cope, clearly implying that support for families is in some cases inadequate. Therefore, the study suggests that that the MHA is often used to prop up a deficit in adequate community services for people experiencing mental health problems and their families and carers. A further point to make here is that notwithstanding a greater emphasis on more robust mental health services, if people were referred for a MHA assessment before a crisis, perhaps in the earlier stages of a deterioration in social functioning associated with mental distress, then this would provide further opportunities to use the MHA where establishing meaningful dialogue would be enhanced along with opportunities

to try less restrictive options to detention. In this way, a MHA assessment could be a gateway to providing mental health services in the community.

There are further implications raised over the organisational deficits when referrals were made to assess people who were already detained under section 2 MHA. Here, referrals were poorly timed and often made on the day that the section 2 MHA expired. This could be changed. The hospital should, according to the Code of Practice MHA, decide at day 14 whether a person subject to section 2 MHA will be referred for section 3 MHA; in any event the hospital have 28 days. It is obvious that referring at day 27 or 28 works against the interests of the person detained, and works against the AMHP orienting action to emphasise human rights. If these referrals were made earlier then the rights of the person could be further enhanced by providing advocacy or legal representation at the point of being assessed under the MHA. Further, participants often opted for detention in hospital over the person being discharged from hospital. This was normally based on a lack of feasibility or availability of plans to support the person in the community. This suggests an important implication for community support plans to be established at an earlier juncture in the admission to hospital.

3.3 Future Research

The implications of the research study for future research involve three main areas of focus: social factors impacting on decisions to detain; action oriented to human rights; and enhancing communication with people experiencing acute mental distress when using the law.

The research study found that whether the person assessed is detained is, in many circumstances, as much about others as the person themselves. Law is also used to respond to the needs of others; the notion of 'detainable' hinges on numerous contingencies and not solely on individual mental disorder and risk. Therefore, there is a case for further research to explore whether there are other ways of responding to the needs of other people, for example family members, that do not necessarily lead to the detention of the person assessed.

Understanding how family members are supported prior to the MHA assessment might illuminate further understandings of why a MHA assessment becomes the answer. This leads to a key research question arising from the research: how can we reconcile needs of families against rights of individuals in mental distress without resorting to detention? Future research needs to conceptualise what is meant by a social perspective and develop a model which includes a commitment to recovery and rights perspectives.

The research study highlighted a dynamic and nuanced interplay between autonomy and coercion, where coercion was usually privileged over autonomy in the short term to enable greater autonomy in the longer term. There is therefore an argument to undertake qualitative longitudinal research focusing on outcomes over time to ascertain how the dynamic plays out in relation to individuals' longer term autonomy after they have been detained under the MHA. This would also focus on exploring how the ruptures in relationships between family members arising at the time when someone is detained are addressed by families when a person is discharged from hospital. The research study highlighted that family members can no longer cope with the person assessed, which is a key factor in the person being detained. This gives rise to further research questions: What happens to those relationships afterwards? How do people removed from their families in the context of being detained under the MHA reconcile with their families? How are these social contexts addressed during the hospital admission?

3.4 Action oriented to human rights in teaching and learning

A further key implication for research arises in response to the habitus of AMHPs discussed above, which raises the need for an exploration of action oriented to human rights in classroom and practice placements for AMHP training. The same question could be asked in relation to pre-qualifying social work education as most AMHPs are social workers. This leads to a further research question focusing on qualified AMHPs to explore the extent to which rights-based approaches are emphasised in AMHP supervision and at AMHP practice forums. This is closely linked to areas of future research in relation to

communication and acute mental distress, and supported decision-making in the context of MHA assessments.

3.5 Communication and acute mental distress

The implication here, arising from the study, is the need for the service user voice to be heard during the process of MHA assessment and, in doing so, for action oriented to human rights to incorporate supported decision-making. This is an important area of future research that incorporates principles of procedural justice as an emphasis when using the law in social work AMHP practice. The focus on service user voice orients action to human rights by seeking to support those experiencing acute mental distress to make their own decisions as much as possible and to have their voices heard, notwithstanding that this might be in the context of a compulsory admission to hospital in some circumstances. Following on from this, an important question for future research is: How do you find meaningful dialogue with someone who opposes you and is experiencing acute mental distress, such as acute psychotic symptoms?

Research focusing on communication when using the law should include a focus on legal mechanisms such as advocacy under the MHA and advance decisions. In addition, mechanisms of practice such as relational social work, recovery-based approaches, and advance care planning should also be explored. The priority for research on enhancing communication through supported decision-making needs to focus on how to orient action towards human rights perspectives in difficult cases where acute mental distress, opposition and competing needs are in tension with obtaining a meaningful dialogue with the person assessed. The research study shows that basic mental health support in the community has often broken down prior to the person being detained, and that the community cannot be envisaged as a place where plans could be put in place to enable someone to be discharged from hospital. The question of how to enhance communication through supported decision-making needs to take account of this atmosphere of mental health practice when responding to difficult cases. A starting point could involve conducting in-depth qualitative research on the experiences of service users in

relation to how they experience their 'voice' in the process of being assessed under the MHA.

4. Dissemination of research

A contribution to the body of knowledge in this area includes plans to present the research at conferences and plans to publish in academic journals. I have started to disseminate my research by presenting an overview of the research and initial findings at the European Conference for Social Work Research(ECSWR) in April 2017. I will be presenting implications of the findings at the ECSWR 2018 conference and I plan to submit abstracts to the annual U.K. socio-legal studies conference series to disseminate my research to an inter-disciplinary audience.

I am applying for post-doctoral research funding via a small grants scheme at Kingston University and St George's, University of London to enable me to carry out a research project based on the proposals for a future research agenda, highlighted above. I have also joined a faculty-wide mental health research group at the faculty of health, social care and education at Kingston university and St George's University of London to pursue the research agenda further.

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Appendices

Appendix 1 - Participants information sheet

RESEARCH STUDY PARTICIPANTS INFORMATION SHEET

You are being invited to take part in a research study. Before you decide whether to take part, 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.

The researcher is Simon Abbott, a social work AMHP with London Borough of Croydon and a doctoral student at the department of Social Work and Social Care at The University of Sussex.

Study title:

How do social work AMHPs use the law in their decision-making under the Mental Health Act 1983?

What is the purpose of the study?

The purpose of the study is to explore and make observations about the way that the relationship between law and social work is played out when social work AMHPs make decisions under the provisions of the Mental Health Act 1983. I am interested in gaining insights into how the law is used in social work decision-making.

Why have I been invited to participate?

You have been invited to participate in this study as you are a registered social worker and a warranted practising AMHP.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. If, after you have participated in the research, you change your mind about wanting your contribution to be included, you can ask for this to be withdrawn up to the point at which it has been included in any written or verbal presentation.

What will happen to me if I take part?

You will be asked to take part in a 1 to 1 research interview with me lasting up to one hour.

During the interview, you will be asked about your experiences of undertaking and making decisions under the provisions of the Mental Health Act 1983. If you agree the interview will be audio taped in order that I have an accurate account of your contribution.

You will also be asked to keep a contemporaneous practitioner diary to record your feelings and thoughts immediately following your decision-making under the Mental Health Act 1983. This will involve 15-20 minutes on approximately three occasions.

You will be offered a follow up 1-1 interview with me, following completion of the diary entries.

What are the possible disadvantages and risks of taking part?

There should be no disadvantages in you taking part in this research. The time involved will be approximately 1 and a half hours of your time. Some of the experiences you wish to discuss may be emotive. If you are finding this difficult to discuss or if you become upset I will check whether you wish to continue. You are free to stop the interview either temporarily or permanently. The content of what you wish to discuss will be entirely under your discretion and no pressure will be put on you to discuss things you are not comfortable discussing.

What are the possible benefits of taking part?

Your contribution will be valuable to the furthering of knowledge about how AMHP social workers use the law. I consider that gaining a perspective from those at the front line of applying the Mental Health Act 1983 in real world situations is crucial to gaining insights and understanding of the relationship between law and social work decision-making in this area. There may also be a professional benefit to you in reflecting on and sharing your experiences as a practicing AMHP.

Will what I say in this study be kept confidential?

Information that you provide will be kept confidential, no information that you disclose will lead to the identification of you, any other individual or organisations. Your name will not be used or stored with the data transcript of your interview. Any characteristics that could identify you will either be omitted or changed in order that your confidentiality is maintained. There will be nothing to link the consent form that you sign to the information you provide in the interview. All data collected during this research project will only be used for the intended purpose as described and this will always be presented anonymously. Client confidentiality will be upheld.

The only exception to the above statement on confidentiality is if something you say indicates a significant risk to service users or others. If this arises I may need to share the information with another person within or at the organisation. If this is the case I will discuss with you how this information should be passed on to relevant parties and why.

The audio taped interview will be deleted once it has been transcribed and the transcriptions of interviews will be held on a password secured computer and destroyed once the research is complete.

The practitioner diary will be destroyed and the transcriptions of the diary will be held on a password secured computer and destroyed once the research is complete.

What will happen to the research?

The research will be presented in the form of a thesis to fulfil the Doctor of Social Work that I am undertaking at the University of Sussex. It may also be published or presented as part of an academic paper.

Who is organising the research?

The research is being organised via The School of Education and Social Work at The University of Sussex.

Who has reviewed the study?

The research is being supervised by Professor Suzy Braye, Professor of Social Work and Social Care at The University of Sussex and Dr David Orr, lecturer in Social Work and Social Care at The University of Sussex and has gained ethical approval from The School of Education and Social Work at The University of Sussex. The study has been reviewed by the Committee for Research Ethics – Social Sciences/Arts at University of Sussex. The relevant approval reference is; ER/SA455/1.

Is there anything else I need to know about?

In the context of this study, my role in relation to you will be solely as researcher. No prior information that I have been party to in my role as an AMHP will have any bearing on the research or will be used in any presentation of findings. The information used will entirely be that which you voluntarily provide to me during the interview. The purpose of the research is not to judge you in any way but rather to value the contribution you can make and insights you can provide to this subject.

Who could I raise concerns with if I have any at point during the research?

Professor Suzy Braye

Department of Social Work and Social Care at The University of Sussex

Suzy.braye@sussex.ac.uk

Contact for Further Information

Please contact me if you would like any further information before deciding to take part.

What should I do if I want to take part or want further information?

Please email or phone me on the contact details below or speak to me directly and we can arrange a mutually convenient time to meet or I can answer any further questions.

Simon Abbott

July 2014

Appendix 2 - Participants consent form

PROJECT TITLE:

How do social work AMHPs use the law in their decision-making under the Mental Health Act 1983?

Project Approval Reference: ER/SA455/1

I agree to take part in the above research project. I agree for the interviews to be recorded. I have had the project explained to me and I have read and understood the Information Sheet, which I may keep for my records. I have had the opportunity to ask questions. I understand that agreeing to take part means that I am willing to be interviewed.

YES NO

I agree to keep a practitioner diary and be interviewed about the diary

YES NO

I understand that any information I provide is confidential, and that no information that I disclose will lead to the identification, by anyone other than the researcher, of any individual or organisation unless there is a concern about significant risk to service users or others.

YES NO

Any such issue will be dealt with as outlined in the Information Sheet.

YES NO

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised.

YES NO

I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Data Protection Act 1998.

YES NO

Name:

Signature

Date:

Appendix 3 - Topic list for interviews

The purpose of this interview is to elicit AMHP practitioner 'stories' of their experiences of carrying out Mental Health Act assessments that they have recently undertaken. This will involve talking in-depth about a recent assessment. Interviews will be flexibly structured to be able to follow the detail of the work that has been done.

Introductory information to cover;

- Job role and professional qualification
- Length of time in post, as an AMHP and in adult social care more generally
- Definitions and understandings of AMHP role under MHA.

Core questions;

Please tell me about a Mental Health Act assessment that you recently undertook. I'd like to hear about the circumstances of the referral, what the issues were, and how the assessment played out on the day, including what the outcome was. I would like to hear about your experience of using the Mental Health Act in practice and any challenges that you encountered and any learning points?

Follow up questions;

- How did you feel before, during and after the assessment?
- Could you speak about the nature of the risks involved?
- Were there any (risk) events that triggered the referral for a MHAA?
- What section of the Mental Health Act was being considered and why?
- How did you decide what the outcome would be-i.e. detained or not?
- Did everyone agree? Why/ Why not?
- Could you explain what you saw as the relevant circumstances of the case that influenced your decision?
- Could you talk about the NR-what were the issues/challenges?
- Were there any challenges in terms of your autonomy as an AMHP at any stage (either prior to during referral or MHAA?)
- Are there any lessons learned?
- Is there anything in hindsight? Would you approach it again in the same way?
- If you were talking to a novice about this case what would be the learning points?
- Did you discuss the assessment with anybody?
- Is there anything about the assessment that bothers you?
- Did you consider any alternatives?

-
- 5 How do AMHPs use the law in practice in the context of assessment for admission to hospital under the MHA?

Sub questions for consideration are:

- d) How does the concept of legal literacy translate into social work AMHP practice?
- e) How do AMHPs employ a social perspective when using the law in practice?
- f) How do AMHPs describe their work using the law in practice?

Approved Mental Health Professional practitioner diary

Please complete following a Mental Health Act assessment

If you have any questions about your diary please
email Simon Abbott at s.abbott@sussex.ac.uk

How to fill in your diary.

Thank you for your help in agreeing to participate in this research project.

- Remember that this is your diary. I am interested in finding out as much as possible about your experiences of using the Mental Health Act 1983 in practice. So please tell me as much as you can about your experiences in undertaking a recent Mental Health Act assessment. I am interested in hearing about the challenges and dilemmas present for you in the assessment. I am interested in your thoughts and feelings about the assessment and your reflections on it.

- Please tell me what happened from receiving the referral to completing the assessment.
- Please write about your feelings/experience at the time and what you were thinking.

Diary

What happened?

What were you thinking and feeling during the assessment?

.....

Appendix 5-Ethics approval certificate



University of Sussex

Social Sciences & Arts Research Ethics Committee CERTIFICATE OF APPROVAL

Reference Number:	1112/05/04
School:	ESW
Title of Project	Social work and legal decision making: AMHP social worker narratives regarding mental health act assessments
Principal Investigator: (Supervisor)	Simon Abbott (Prof Suzy Braye)
Expected Start Date:*	01/07/2012

*NB. If the actual project start date is delayed beyond 12 months of the expected start date, this Certificate of Approval will lapse and the project will need to be reviewed again to take account of changed circumstances such as legislation, sponsor requirements and University procedures

This project has been given ethical approval by the Social Sciences/Arts Research Ethics Committee (C-REC). Please note the following requirements for approved submissions:

Amendments to research proposal - Any changes or amendments to the approved proposal, which have ethical implications, must be submitted to the committee for authorisation prior to implementation.

Feedback regarding any adverse and unexpected events - Any adverse (undesirable and unintended) and unexpected events that occur during the implementation of the project must be reported to the Chair of the Social

Sciences C-REC. In the event of a serious adverse event, research must be stopped immediately and the Chair alerted within 24 hours of the occurrence.

Authorised Signature



Name of Authorised Signatory (C-REC Chair or nominated deputy)

Dr Elaine Sharland 27/07/2012

Appendix 6-AMHP case story

Int⁴: So, the purpose of this interview is to elicit AMP practitioners' stories of their experiences of carrying out Mental Health Act assessments that they've maybe recently undertaken, and this involves talking in depth about a recent assessment, and the interviews flexibly structured to be able to follow the details or work that you've done.

R⁵: Okay.

Int: So, we've got an introductory question and then a core question.

R: Okay.

Int: So, in terms of the introductory information, could you just tell me about your job role and professional qualification?

R: So, the social work part and the AMP part, so social worker trained. Um, been working for about six, six, seven years. Started off in children, children and families and then moved into mental health, and I've been an AMP Now for a year and a half.

Um, was currently working in mood and, mood and anxiety personality disorder service, bit of a tongue twister, um, where I'm based mainly, and then I do, I'm on the AMP rota, which I do five days a week probably every two weeks and a half. Yeah.

Int: Great. Thank you. So, I'll just move onto the core question, so could you tell me about a Mental Health Act assessment that you recently undertook, or one that you can remember. I'd just like to hear about the circumstances of the referral, what the issues were, how the assessment played out on the day, including what the outcome was, and I really want to hear about your experiences of using the Mental Health Act in practice, and any challenges that you encountered or any learning points.

R: I have a good one [laughs]. Um, so this was a xxxxxx man, xxxx man, um, but British err, resident, and his wife had become concerned of late. He was known to the recovery team, which is, um, people with psychosis, and he had a diagnosis of schizophrenia.

The team had lost contact with him probably for the last six months. He hadn't been taking his depot, which is what his treatment is prescribed for, for the schizophrenia, hadn't been taking his depot. They'd been trying persistently, um.

⁴ Interviewer

⁵ Respondent

Then it came to the point where the, I think the care coordinator hadn't been consistent, which I notice is quite often sometimes the site recovery teams, when people, um, have, lose contact with the team, it, it's kind of left for a while and then it's like ooh [laughs], they do a quick kind of check on caseloads, well we haven't seen this person for a while.

So, it was a bit of a time he hadn't been seen and I'm thinking hadn't he been out of hospital, was doing well for a bit, and then I think team lost communication with him, so now they were trying to, um, start him back on the depot, because he'd missed one and he'd gradually declined, so the, but the wife was concerned because he was becoming irritable and shouting at the family, and he wasn't saying things that made any sense.

So, the team coordinated and the doctor went around and saw him briefly, and the doctor completed a medical recommendation. Then the assessment was set up.

Um, the warrant was obtained. He lives, his, he and his wife own the property but his wife would not be at the property at the time of the assessment. She was at work.

Um, she was worried about being left on her own. She said, "I don't stay with him on my own", um, cos he, he, he threatened her but in a psychotic kind of content, like because of his thoughts or his delusions that he's having, so she's unsure if he, he hasn't actually, he didn't, he hadn't hit her, but she was concerned, she didn't know what he was doing, he's unpredictable.

So, she gave us some information. He hadn't been seen by the GP. He was also, um, taking medical-, well he wasn't taking medication for epilepsy but he also had epilepsy, but he had been reviewed.

I checked all the notes. That's what I usually do before I go out. I check, um, the computer system we have to see any kind of, any other services that may be involved, and this gentleman was known to xxxxxxxx service, so when he was seen he actually was okay in his presentation, but his wife wasn't in the, didn't go into the session.

Um, that was the following year, the end of the following year, so this assessment I did a few, a couple of months ago. He was seen by the neurologist maybe November and that was the last professional to have seen him for some time properly.

So, it was clear that there'd been a gradual decline, cos after that then he stopped having his depot, so the following year he'd stopped having his depot.

Um, he's a retired gentleman. I can't remember what he did, but he, he was at home most of the time, um, and I think would pop, pop out to the local community thing. So that had also stopped. He wasn't leaving the house. He wasn't eating properly. He wasn't sleeping.

So, considerable decline in his current day living, um, skills. Um, he'd also made threats. So that, I think, was, the main concerns were the family didn't feel safe round him.

So, the assessment was convened. I attended with, um, one section 12 doctor and two police officers, so um, the client, we knocked on the door. He didn't open it. We, how did we tell he was inside? I think we might have called through the letterbox and he shouted something at us that you can't come in or we're not, go away or something.

So, we then used the warrant, the police used the warrant to, to gain entry. Um, I left a copy in the house, the police had a copy and I took a copy. Um, so this was an assessment that I thought, we got in and he didn't want to talk to us and he was saying, um, we should leave.

Now usually, you know, the 135 is to remove the person, yeah, once you gain entry-, gain entry then remove if necessary. I suppose as AMPs we, we kind of, the last resort is moving if necessary, we go in and if we feel it's safe to carry out the assessment with the police, we usually would do that with normal practice.

On this occasion, because he was telling us to get out, he wasn't talking, um, he was just shouting at us, he was shouting things that didn't make sense. I can't remember the content now, but it, it, it was, it was more deluded content and, and shouting, and he was quite rigid in his, where he sat. He wouldn't ...

So yeah, so then we said, okay, so I went and had a discussion with the section 12 doctor. The police kind of, um, were coming in and out of the kitchen and I was saying "I don't know if we can assess him suitably, um, here, and I think we may need to con-, consider taking him to the 135s, the place of safety suite, um, and the police were happy to do that, um.

And then something changed. He then, he then, we then were able to talk to him a bit more and then have a di-, he then started to say other things and not just get out and, and stuff, so we were able to speak to him and ask some questions, but he was clearly unwell, so from the interview that we did do, we thought it was a suitable, I thought it was a suitable interview, um, you know, he was in a comfortable place, he could answer questions if he wanted to, so we were able to gather enough information for the doctor to make a medical recommendation.

And then I, um, felt that his quality of life is not one that he would normally be living. If he was well, he wouldn't be living like this, um, and for some reason he's declined and I, and I agreed that I think that he needed to, there was a risk to his family. He was not eating, he was not looking after himself, so there was a risk to family and his health and safe-, in health and safety, so I completed my application.

So, from that stage it then became a bit complicated, cos I then said to the police officers, "okay, um, I have two med recs and my application, can we now com-, um, the ambulance is on its way, when the ambulance come, I'd like to convey this gentleman to the local hospital", and the police, there was two, one maybe more senior or, or one was saying "well we don't do that, we don't" ...

And I said "he's unpredictable", um, I believe you have to have, you, when you go in, your mind-set needs to be quite broad, can be, okay, so this could happen, is it safe, they could not respond, they could not talk to you, they could get irritable by what you say, and you know, my always initial approach is to build a rapport quite quickly if possible, um, and then take it from there really.

So, there's, I think there's a lot, and then you're coordinating the police and maybe locksmith, um, potentially two doctors. You get, I was lucky that I had one [laughs]. I think I probably prefer having one doctor myself, because I, I find sometimes two doctors, cos you almost have to kind of, um, sometimes err, manage them also.

So, in, in this case, um, I was a little bit anxious what I might find, and during I kind of though oh gosh, this is a typical kind of, you know, assessment can't be done on the premises, whip, whip the person out, get them somewhere safe, blur, blur, and then when it kind of changed to maybe oh we can assess, I felt a bit more relaxed.

And then, and then the kind of conflict with the police ma-, rose as another issue and so in that presentation, in that assessment I think I was up and down [laughs], and, and it was a lot of kind of coordinating it and, and kind of, um, a bit frustrating in some parts of it, and I think as an AMP you try and keep the client at the forefront and want to do the best for that person, and I found, you know, sometimes if the person needs to be in hospital, advocating to get, to get them there, we do quite a lot [laughs], yeah.

So, I think m-, yeah, so from anxious to kind of not too bad to frustrated, I had a few emotions [laughs].

Int: And could you speak about the nature of the risks involved that led to your decision?

R: So, I had a, um, risky situation presented by xxxxxx, who's, who's his carer and I think there's, carers can sometimes have a difficult time in trying to access services, and I find that, um, we need, I find that sometimes they can struggle to get in, like people don't always take them seriously, people think oh, you know, they're just exaggerating what's going on.

And I, I think that when it gets, especially this level of Mental Health Act that it's, it's serious and we need to consider seriously what the family

are saying, and if they're living in a risky situation, we need to look at, look at that and see how those risks can best be managed, um.

I think when, if, once the wife is saying to you that "I can't stay in the house on my own, um, because I'm scared that my husband might hit me, and it's a result of his mental disorder", then that's going to, you know, bring up, raise the level of risk, um, and he's not aware of the risk he presents either, so there's no kind of way that that risk can be minimised if someone's that unwell that they have no insight into how they're behaving, so those were kind of areas that I will I-, I was looking at, um.

He had, um, I can't remember if he'd, he was, the threats were quite serious, like he would, you know, he was going to get some people to attack his daughter or something. So they were, not that he could, but he was, in his mind it, that's what about the unpredict-, going back to the unpredictability, you, you just, some people you just don't know what they could act-, because if they're, they're having these thoughts or, you know, and delus-, delusions or any kind of psychosis that could precipitate something, then you want to make sure that you contain that situation as best as possible.

So, um, and I think the fact that he had no insight at all into his illness, then increases the risk even further. Yeah.

Int: Sure, and how did you decide what the outcome would be, sort of detained or not? How did you decide that do you think?

R: And I think the decision was based on the fact that he could not engage with us. He could not form any, any kind of conversation about his illness. He would just make comments like "kill me, kill me", um, "kill yourselves", um, you know.

There, there was no, he was, he was extremely thought disordered, um, and that's where I was thinking this man, you know, it's quite terrible, you hear in all sorts of the media and you just hear all these stories where people were saying all sorts of things [laughs], and they weren't taken seriously, and you don't know, like I say, the unpredictability, I'm not quite sure what you could have done, um.

And his, his disorder needed treatment to manage those to, to kind of reduce any risk, cos when he was well he was, he, that behaviour was very different. He didn't behave in that, in that kind of threatening, aggressive, he was being aggressive to the wife.

I'm sorry, I can't remember if, if he had hit her. I know the threats were worrying. Yeah. Yeah. Yeah.

Int: And could you talk about the nearest relative, what were the issues or challenges?

R: So yes, his re-, his nearest relative was his xxxxxxxx. Um, xxxxx was trying to cope with xxxxxx who she was concerned about, um, and she felt he needed to be in hospital. She knew that he wasn't well. She knew that she couldn't stay at home safely with him on her own, and she actually was working in co-, in cooperation with services, so any information we needed, she tried to provide that.

Um, like I said, she was, she works nearby so she, I think having work, I think having an escape for her was very good I think, and I tri-, and I remembered speaking to her and allowing her to kind of have some kind of, somewhere to vent, cos I find talking to nearest relatives, you hear a lot about their stresses, and I, I know we have obligation to have informal consult, but I think it's a bit more than that. I think it's about hearing what they have to say, cos they're very important people, um, generally.

Sometimes they haven't seen the person for, you know, nearest relative is quite [laughs], nearest relative is, is not random. In a sense, it can be random because it depends on a list and not, not necess-, and you know, obviously care and lived with, but sometimes those things are applicable, um, and the nearest relative sometimes has little to do with the person that you're assessing.

So I always find it almost fortunate when the nearest relative is in the person's life and has a, has a role, um, and in this case the nearest relative did and I found it quite helpful to gain an unders-, a better understanding of the person I was going to assess, cos obviously you assess and you look for, it's independent but also it's based upon information that you, circumstances that lead up to the assessment, so it's not in-, information you get from the nearest relative is not received in isolation but it's, um, used to help you form a judgement. Yeah.

Int: Great. And you spoke a little bit about it, but were there any challenges in terms of your autonomy as an AMP on that assessment?

R: Yes, um, so yes, I spoke to, I spoke about the relationship, the issues I had with the police officer and the autonomy, because in a sense they were saying "well yes, it is your assessment [laughs], and you're the, you're responsible for this person", um, so almost giving me that kind of independence or decision-making, but then at the same time they were like, well you, yeah, yes you make the decisions, but we're not going to be part of the decisions that you make, um, or we're reluctant to or we've, or we're told we can't or, you know, and I just, and I think that affected the autonomy line.

I think it, um, even though we, actually I think we assess in team in a way, um, cos each person has a role, and as an AMP you're, I think in xxxxxxxx we're quite fortunate, because even though you go out there and you assess and make your decision independently, um, I find that sometimes you need, you still need to reflect, and maybe something's

happened like in this case, and I was, in this case when I felt that my autonomy was kind of, um, almost disregarded, my AMP lead was, is very helpful in going back to and debriefing and reflecting on a situation.

Cos I did reflect about that situation to think how maybe I could have done something differently, could I have done it diff-, you know, could I have maybe said something different or something, um, and you know, so even though being autonomous, I think we should all kind of reflect on how we carry out our role, um, but yes I did have a few, yeah [laughs].

Int: That brings me onto my next question; are there any lessons learned for you from that assessment?

R: Never assume the police are going to [laughs], going to [inaudible, laughing 24:49]. Yeah, definitely, um, cos if something hasn't happened before, you kind of think it's not going to happen, and you might have a difficulty and it, in, in just a short time, time I've been an AMP, um, I've had varying different experiences with people who attend Mental Health Act assessments, the police are always consistently, um, part...

Not always, but cos they're another service that's consistently part of an assessment, and I think I won't ever assume that they will be there to, that they will know why they're there in a sense, which is kind of what I took from this case, and I'm going to be more prepared with documentation that we actually have that clearly states that they can, um, they, to give them the authority to convey.

So that's kind of given me that, um, that kind of knowledge to maybe not assume and say "look, this is here, it's all laid out [laughs], this is what you, I can give you the, the authority to do". So I think yeah, from that case I've learnt that. Yeah.

Int: Great. Excellent. And if you were talking to a novice, maybe a trainee AMP, talking to a novice about this particular case, what would you tell them is a learning point would be for them?

R: So maybe be prepared for any, be prepared for, um, be prepared for a situation not to run smoothly to have to defend your position, um, and I think that's quite a scary thing to say to either, to a trainee AMP, because I think the course itself is quite, um, overwhelming, um, and then to hear that you have to learn all this law, and then when you try and apply it, people don't, you know, adhere to it or trust what you say, and, and that you might find it difficult.

So, I think to a novice I'd probably say, "reflect on each case and learn as, as much as you can", so in this case I'd say probably definitely reflect on what I've done, and definitely prepare myself for certain eventualities for the next time round, because the police are going to be people or a service that are always going to be in an AMP's life [laughs].

So, it's about preparing yourself for certain eventualities. Obviously, there's some you're not going to be able to, but ones that you can maybe assist the police, and that's how I see it. You still want to work as a team, um, so how you can assist your colleagues, um, in understanding their duties.

Probably that's what I would say to a n-, you know, a novice. You need to know what you're doing cos you have to convey that to others, and sometimes you might need additional, um, tools to help them, you know, help them assist you in, in what, what they need to do. Yeah.

Int: Great. So, this is just a final question, can you just talk to me a bit about the alternatives available to the decision that you make...

R: Yeah sure.

Int: ...you know, how you considered them and what the issues were...

R: Yes.

Int: ...how you discounted them [overtalking 28:04].

R: Yes. Yes. Yes. So as an AMP, always go with the least restrictive in mind, um, and that could be, it has its limitations [laughs], you know, so you've got the home treatment team is one option, um, in, in most boroughs, so in xxxxx there's a home treatment team, and personally I think they should be attending with us to [inaudible 28:33] Mental Health Act assessments, but due to pressures on the service they can't, they can't do that.

So, um, that's something I always go to look for, if this person does need treatment, how can the treatment be given? Does it need to be in the hospital setting? Does it need to be, could it be at home? Or, does this person need treatment at all? Maybe they don't need anyone to come in and see them every day. Maybe it's just that, um, they didn't kind of, err, understand the, the crisis or how it got to this point, cos that can happen as well.

So, in, in this case you go in looking to see how you can avoid, I always go in to see, I always go in with the starting point, how can I avoid someone or a person going into hospital? And I kind of went in with that.

And a lot of the time it depends on the person's understanding about their illness. That's I think my pri-, that's how I, um, make my decisions a lot of the time. What do they understand about their situation and what's happening? Do they understand that people are concerned about their behaviour?

Now this man had no understanding of what was going on, how his family felt, that he needed to take medication and I think to, from that starting point you, you kind of, for, for home treatment team the person

needs to be willing to engage at some level, um, at least for someone to be coming into your house on a daily basis, and it's, it's a kind of, it's a, it's an intrusion, but it's a lesser intrusion than them going into hospital.

And I need to be in a position to help them understand, okay I personally don't think you may ne-, you need to be in hospital but I think you do need some intervention, and so that person needs to be enga-, needs to be able to engage with me to have that discussion. If they're not able to do so, then I, I, I couldn't, the evident, there wouldn't be any evidence to say this person would work, this treatment would work in the community.

Um, and as we know, informal, um, um, informal ad-, admissions work best if someone has capacity. Um, you know, there's things you have to consider about depriving someone of their liberty if they don't have capacity and, but they go willingly into hospital, and this, this gentleman was not going to go willingly so, and he didn't have the capacity to make a decision about hospital admission. So, they're, they're the two things that I look at prior to, to kind of completing my application.

Int: Excellent. Thank you.

Appendix 7-A case story: using the law in practice

This section provides a precis of an entire case story from start to finish (Full transcript available in appendix 6). This serves as an illustration of the narrative that participants shared during the interview. The rationale for doing so is to give a good idea of the raw data that was obtained. This also enables a demonstration of how a whole story illustrates the themes that emerged from the cross-sectional analysis of the data.

The AMHP told me about the referral, that it related to a middle-aged man whose wife was concerned about him. He was under the care of a community mental health team, and has a diagnosis of schizophrenia. The relevance of describing the man's diagnosis is that the MHA only applies to people who are believed to suffer from a mental disorder, by virtue of section 1 MHA. The story developed with the AMHP describing how the team had 'lost contact' with this man for around six months and that he had not been given his prescribed depot injection over this period. (The treatment of anti-psychotic medication in the form of a depot is related by the AMHP to his diagnosis of schizophrenia).

The AMHP explains that the community mental health team had been trying persistently to contact this man for a period but that there had been a point when this persistence dropped off. The team had not been consistent with assertively following up on the man's disengagement, pointing out that this sometimes happens before a team will 'do a quick check on case loads' and act on the fact that they haven't seen someone for a while. The notion of the adversarial atmosphere characterized by the legal wind chill factor described under theme 1 is apparent here and in the account of the organizational factors accompanying the referral, described by the AMHP in the following paragraph.

The AMHP presented the fact that this man had not been seen by mental health services for a while as an organizational factor impacting on the context of the referral. At this point she gave a summary of her thinking by outlining the issues accompanying the referral, which included the following: he had been

discharged from hospital; he was doing well for a while; then the team lost contact with him; now they want to get him back on the depot; he has gradually declined; he is causing concern to other people, notably his family who reported that he is becoming irritable, shouting, and saying things that don't make sense. The doctor from the community mental health team visited the man at home and following this visit completed a medical recommendation for section 2 MHA, which triggered a referral to the AMHP for a MHA assessment.

In the following paragraph, the themes of 'understanding the individual (Theme 2) and understanding the situation causing concern (Theme 3) are apparent.

The AMHP explains that a warrant was obtained, before explaining that whilst he lives with his wife she would be at work at the time of the MHA assessment and therefore would not be able to open the door to let the assessors in. The implication here was that the AMHP believed that the man would not let the assessors in. The AMHP then explained that she spoke with the man's wife face to face and describes that she had spoken about being worried about being left on her own with her husband and avoided being on her own with him because he has threatened to hurt her. The AMHP explains that these threats are made 'in a psychotic kind of way', describing the man's wife talking about her husband's thinking as 'psychotic' with 'delusions'. The AMHP reflected that the man's wife didn't know what he was going to do next before explaining 'he's unpredictable'. The man's wife provided the AMHP with further information; he hadn't been seeing his GP for physical health problems and has not been taking medication prescribed for his physical health difficulties.

In the next paragraph theme 3 understanding the situation causing concern emerges again.

The AMHP then described looking at the notes held about this person, explaining that this is what she usually does 'before I go out' (meaning before I go out on a MHA assessment). The AMHP gave a rationale as to why she looks at all the notes as to check if any other services are involved with the person. She saw that the man was known to another service and that they had

seen him and were not at the time, according to notes, concerned about his mental state. The AMHP reflects that for this appointment the man was on his own and that as his wife was not present this service would not have had the benefit of collateral information from her to relay her concerns about her husband.

The AMHP describes that this appointment was where the last professional had seen the man 'properly'; she explains the time frame and proposed that this information had led her to believe that the decline in the man's mental state had been 'gradual'.

An indication of his social functioning was given, describing the things he would do in the community. This was contrasted with the concern accompanying the referral about the man not leaving the house anymore, not sleeping, not eating properly. The AMHP concluded that there had been a decline in his social functioning. This was punctuated with a description of the man having made threats to his family who didn't feel safe around him.

The themes of 'understanding the individual (Theme 2); understanding the situation causing concern (Theme 3) and; 'community versus containment' (*Theme 4*) all appear in the next two paragraphs.

The AMHP then reaches the point in the case story where the MHA assessment is carried out at the man's home address, describing that the assessment was 'convened'; she described that she attended the man's home with 'one section 12 doctor and two police officers'. The AMHP describes knocking on the door and that 'he didn't answer it'; this is followed by describing how she knew whether he was home: she called through the man's letter box and heard him shouting at them to go away.

The AMHP described the warrant being executed by the Police officers and that a copy of the warrant was left at the address, explaining that the police kept a copy and that the AMHP also kept a copy. The AMHP describes that this was an assessment where we 'had got in but he didn't want to speak with us, telling us to leave'. Executing the warrant meant that the AMHP, doctor and police entered the property without his consent.

The AMHP contrasts this situation with previous warrants that she has experienced, explaining ‘usually, you know, a s135 is used to remove the person’, but it is common practice for AMHPs to assess the person in their home, reflecting that removing the person before assessing them is the ‘last resort’, and reiterating that the normal practice is to assess someone in their home, if they (the assessors) felt safe to do so. However, the AMHP describes an impasse in being able to have any kind of dialogue with the man that could facilitate a suitable interview with the man under the provisions of the MHA; “he was just shouting at us” “he was shouting things that didn’t make any sense”, “I don’t remember the content now...but it was more deluded content”.

The remainder of the entire case story is captured by the themes of relationships and resources (Theme 5) seen in the account of inter-professional and inter-agency working relationships. Understanding the individual (Theme 2) emerges in the AMHPS account of attempts to engage with him. This involved understanding the situation causing concern (Theme 3) that led to the AMHP addressing the risks involved, weighing up the arguments for community versus containment (Theme 4).

At this point in the assessment the AMHP had a discussion with the section 12 doctor in the man’s kitchen. She explains that the police join the discussion, giving their view that they think that it is not safe to assess the man in his house and that they thought he should be removed from his home and taken to a place of safety. The AMHP describes that the Police were ‘happy’ to do this.

The AMHP recalls “and then something changed”, describing that the man was now more willing to engage in some dialogue and was no longer just shouting at them to leave. The atmosphere in the assessment was now more conducive to interviewing the man in his home. The AMHP described that an interview was carried out that was ‘suitable’; that the doctor could get enough information to make a medical recommendation, recalling that the man was very unwell.

At this point the AMHP now had two medical recommendations, one from the team doctor who triggered the referral and now another from the independent doctor who has accompanied the AMHP on the assessment.

The AMHP described the reasons for considering that she ought to make an application to detain the man, explaining that she felt his quality of life is compromised and is not the quality of life that he would normally be living and that for some reason his mental health and social functioning have declined. The risk to his family is then highlighted by the AMHP, then the fact that he is not eating properly and not looking after himself. These facts are then related to the statutory criteria for s2 MHA in terms of 'risk to health and safety', explaining that she made an application.

The AMHP describes that 'it became a bit complicated' at the point of updating the police officers that she had made an application and had called an ambulance to convey the man to the local hospital. This is described in the context of the AMHP asking the police to accompany the man to hospital in the ambulance. The response from police was described by the AMHP as being 'we don't do that', the AMHP replying that 'he is unpredictable'.

The AMHP explained her experience in terms of how she usually approaches a MHA assessment, describing that 'your mind set needs to be quite broad', in other words be open to any eventuality; 'build rapport quickly if possible', 'and then take it from there'.

The AMHP then describes some of the inter-professional and inter-agency challenges encountered when undertaking MHA assessments, explaining that there is a lot going on with coordinating a locksmith, police and 'potentially two doctors'. At this point she laughs that she was lucky to be able to get one doctor with her, reflecting that she prefers going out with one doctor as when you have two doctors together you then have to 'kind of manage them also'. The AMHP then reflected that when she had entered the man's home 'this was a typical assessment' where you would have to 'whip them out to get them somewhere safe' (meaning take them out quickly to a place of safety).

However, once the atmosphere in the assessment changed and they could get some more constructive dialogue then the AMHP describes feeling more relaxed herself.

Reflecting further on her feelings during the assessment the AMHP recalled that the confrontation with Police was difficult and that she experienced a range of emotions including frustration in some parts. She describes that during an assessment she tries to keep the person assessed at the forefront, identifying her motivation to do what is best for that person, and that this can involve advocating for people to be able to get to hospital, if that is what they need.

The AMHP then spoke of the risks that she encountered on this MHA assessment, describing that she had a 'risky situation' relayed to her by the man's wife, whom the AMHP describes as a carer, going on to highlight that in her view carers have a difficult time accessing mental health services, that they struggle to be heard at times and that their concerns can be minimized by mental health professionals, who think that 'they are exaggerating what is going on'.

The AMHP describes that when concerns get as acute as they were in this assessment there is a need to take them very seriously; this is related to a family living in a risky situation and a need to think about how those risks can be managed.

The AMHP described the level of risk that could be tolerated, recalling that once the man's wife was saying "I can't stay in the house on my own because I'm scared my husband is going to hit me, and it is a result of his mental disorder" then this escalates the risk. This is related to the man not being aware of the risks and there being no alternative way of minimizing them when the person is so unwell. These are the relevant factors informing how risk presented during the assessment.

The AMHP discussed the risks by highlighting the relevance of the person experiencing a disturbed mental state, describing how in this assessment the man's mental state made him unpredictable. This situation leads to the AMHP concluding that the risks need to be contained.

The AMHP then describes the reasons for the outcome of detention under the MHA in the assessment. The decision is based on the view that 'he could not engage with us'; 'he could not form any kind of conversation about his illness'. He would just make comments like "kill me, kill me, kill me, kill yourself, err, you know". The man is described as quite thought disordered and the AMHP thinks that the unpredictability needs to be contained. The AMHP described that the man's mental disorder needed treatment to reduce risks, contrasting that when he was well his behaviour was very different, and he did not make threats to harm his family. The AMHP describes the importance of taking concerns from family seriously, and explains that given the concerns expressed a compulsory admission to hospital was the only option: "I am not sure what else you could have done".

The AMHP turned to a discussion about the nearest relative indicating that the man's wife occupied this role and that she was trying to cope with him but was concerned about him and that he needed to be in hospital. The AMHP explains that the man's wife knew that her husband was not well, elaborating that "she knows that she couldn't stay safely with him on her own". The man's wife is described as working in co-operation with mental health services, explaining that "any information we needed, she tried to provide that".

She is described as working nearby, the AMHP suggesting that work provided an escape for her. The AMHP then recalled speaking with her, and describes providing her with somewhere to vent, reflecting that in her experience when consulting with nearest relatives she hears a lot about their stresses. The AMHP describes her understanding of the legal requirement to consult with the nearest relative, implying that the process requires more than adherence to legal rules; "I think it is a bit more than that. I think it is about hearing what they have to say", emphasising that they are "very important people".

The AMHP reflects on her experience and the legal status of the nearest relative in contrast with the roles that they might occupy in the lives of the person assessed, describing the identification of the nearest relative in terms prescribed by law ("it depends on a list"), highlighting that the law allows a

person caring for and living with a person to be given higher priority in the list. She indicates that the nearest relative sometimes has little to do with the person she is assessing, and considers it fortunate when the nearest relative is in the person's life and has a role, as was the case here. This is described by the AMHP as enabling her to gain a better understanding of the person assessed. The AMHP emphasised that the information gained from the nearest relative is not taken in isolation and is used to help her form a judgement.

The AMHP turned to talking about the challenges to her autonomy during the assessment. The inter-agency working relationship with the police posed challenges to her autonomy; she had a sense the police officers were using her autonomy against her in that it was used to undermine the working relationships and roles that were considered important for this autonomy to have meaning. The AMHP describes that in emphasising that she was in charge alone, her autonomy was undermined; "well yes, it is your assessment, and you're the person responsible for this". This experience led to a reflection on learning never to assume that the police will understand their role and of the need to reinforce with police the powers they have under the MHA. Laying all this out for police in terms of bringing a document that contains the law was considered a potentially useful approach to providing police with the authority to convey someone to hospital.

The AMHP indicates that a further important lesson arising from the MHA assessment is to assume that things will not always run smoothly, reiterating the need to be prepared for any eventuality.

Finally, the AMHP turns to talking about how she went about considering less restrictive alternatives to detention under the MHA, explaining that as an AMHP there is a need to always go to an assessment with the least restrictive options in mind, but highlighting that "this has its limitations". She describes the Home Treatment Team as a potential less restrictive alternative in some situations reflecting, that they do not participate in every MHA assessment, although the AMHP thinks they should. Two main questions are described in considering less restrictive alternatives: does this person need treatment for mental

disorder? and where does this need to take place? The AMHP places emphasis on approaching every assessment with the mind-set; “how can I avoid the person going to hospital”?

The least restrictive option is further elaborated on; she describes that this depends on the person’s understanding of their illness, explaining that this is an important factor in how she approaches MHA assessments in her experience. She then relates this to the assessment in question, highlighting that the man assessed has no understanding of what was going on, how his family felt, and that he needed to take medication. The feasibility of a home treatment being able to work with someone in this context was highlighted in terms of this option not being feasible. This less restrictive alternative ‘in theory’ is understood by the AMHP to be an intrusion on the person, but less of an intrusion than being compulsorily admitted to hospital. The importance of the person assessed being able to engage in a meaningful discussion is considered by the AMHP to be a key factor in using the least restrictive option. The AMHP described her thinking about an informal admission to hospital, discounting it in the current case, referring to the need for someone to have mental capacity to be able to agree an informal admission.

Appendix 8- Framework Analysis Chart 3- Understanding the individual.

The insertion of XXX indicates data removed for protection of confidentiality. The chart follows the framework method and commences at stage 6. This involved ordering the data so that material with similar properties was located together to develop a thematic structure. Each main category and associated sub classifications are plotted on a separate thematic chart. Within each individual chart each Participant in the research was allocated a row in the matrix while each sub topic was displayed in a separate column. Each column was assigned a separate number to enable easy referencing between columns. In total seven thematic charts were created covering 57 sub-topics.

Chart 3 Understanding the individual

3. Understanding the individual	3.1 Characteristics of person referred	3.2 Historical events	3.3 Unusual beliefs and behaviour	3.4 Psychiatric Diagnoses	3.5 Views of relevant people	3.6 Participation of person being assessed	3.7 Disjunction between collateral and persons views	3.8 Other
Participant A	Person didn't realise seriousness of his recent behaviour-or was deliberately downplaying it or minimising it. Unable to give any meaningful account for his actions. Blamed others- ("on PD horizon). Insisted he was no longer suicidal and wanted to go home.	Two weeks prior to this presentation he'd been admitted to another hospital following an attempt at hanging. Found by his friend. Two days later the flatmate called the police as he had made cuts to his arm and was threatening to cut his throat. When the police arrived he refused to put down the knife, was tasered and taken to A&E. Was quite aggressive there, threatened and tried to leave. Was placed on 136 by the police officers and brought to the xxxx Place of Safety		Diagnosis is schizophrenia and compliant with medication for this, but also a history of polysubstance misuse and quite a history of serious self-harm. He has never picked up any sort of PD diagnosis but there are considerable psychological and psycho-social issues.		took no responsibility	Never had been fully able to explain his feelings in the run up to this attempt, and it certainly seemed to have had a marked impulsive content. But obviously hanging is a pretty serious attempt. He was found by his friend/partner that he lives with. He rapidly began to say he felt fully recovered, denied any ongoing ideation and was discharged after seven days	
Participant B	He's a xxx man. In conversation was very thought disordered. Difficult to keep track on answering questions. So we felt he was unwell. We did feel he was sincere in saying he would take his medication.	He'd had a party to which a lot of the local youths came. Some of his property was missing after the party.				Person stated very clearly that they no longer wanted to be in hospital. But willing to take medication- thought it helped him but didn't think he was unwell. He gave two conflicting accounts of his home situation that he didn't recognise as conflicting- said that he has supportive neighbours and friends –aso states he is lonely.		
Participant C	And he was a gentleman who was	It was one of those referrals that a young	Well obviously he is clearly unwell- he's			Clearly still unwell, dismissive. Felt		I suppose the difficult being was that there

	<p>actually known to the xxxx service previously, some years before, but he'd obviously not really recovered and still had ongoing mental health issues of psychosis, schizophrenic kind of symptoms that meant that he was unable to participate in life and act accordingly in a safe manner with his family.</p>	<p>man had obviously not recovered. I remembered his name from 6-7 yrs ago from the xxxx team. So it was interesting to go through the history since he was first unwell.</p> <p>With xxxx we are eager to try and resolve peoples ill health so it doesn't become and acute chronic condition- so back to the GP. Obviously this is someone who whatever we had done at the time – really hadn't benefited him.</p>	<p>obviously feeling persecuted, behaving in intimidating and irrational manner.</p>			<p>persecuted by us- misinterpreted and misconstrued us. Several times ran out of the door and came back in. It wasn't an interview as such just a meeting. It was just to see him and experience his difficulties. Wasn't able to participate –lacked capacity to decide o his own best interests. Decided to detain- tried to tell him but he wasn't interested.</p> <p>When we were doing the assessment it was hair raising. he was particularly unhelpful and uncooperative and very unpredictable with his behaviour.</p> <p>it was kind of like you were thinking, mm, well I mean we could just end this interview now, or we could try and pursue him again in about half an hour and to see if he's any more agreeable or cooperative, and that was to just give him his opportunity to at least participate, because it's good practice to at least get somebody into a room and interview in a suitable manner, and allow them all the opportunities to talk about their restrictions to their liberty really.</p>		<p>appeared to be quite poor insight for this gentleman into what kept him well and what stopped him from ending up back in hospital really.</p>
Participant D	<p>'The issues in the assessment were that the guy was very keen not to be detained under a Section 3, he was very articulate.'</p>	<p>but the circumstances of the case, in the level of risk incident that had led him coming into hospital, and he had absconded and also been brought back to hospital in quite risky situations, were such he would not be safe in the community.</p> <p>just if they say everything is fine and</p>	<p>He referred to his mother- concern to me as the notes made no mention of a mother – that would have changed who his NR was. Became apparent that he believes that queen is his mother.</p> <p>In the assessment he put on a good show. Guarded about most of his delusional ideas –</p>			<p>It was quite a difficult assessment in the actual interaction because he was very clear that he didn't want to be in hospital, he wanted to be free. He was willing to consider some form of mediation, although he didn't believe that he had a mental disorder</p>	<p>He referred to his mother- no mother. on file reveals thought the queen was his mother. you feel that you're stitching the person up because there is not much... he couldn't have said... the circumstances were such of his behaviour and his beliefs and his condition, that almost prior to meeting him, it</p>	

		<p>you say... that's not really fair without giving them the evidence that other people don't think it's fine to walk in the middle of the road or whatever are the risky things he was doing.</p>	<p>didn't display thought disorder or any cognitive aspects of psychosis- was clearly deluded but managing to mask it. Was unable to keep himself safe in the community as delusions were so prominent. So you feel in that situation, it's a difficult situation because you feel that you're stitching the person up because there is not much... he couldn't have said... the circumstances were such of his behaviour and his beliefs and his condition, that almost prior to meeting him, it was hard to imagine what he would have to have said that would have enabled me to think that it was not necessary for his health, safety and protection of others to stay in hospital for further treatment.</p> <p>It became clear that the mother was an issue and he didn't want to tell us that his mother was the Queen because he knew that sounded a bit mad. Yet he knew that was what he believed.</p> <p>I hadn't forced him to say his mother was the Queen, but he wouldn't tell us who his mother was, but I knew that from previous notes and I checked with this brother that their mother wasn't alive. So that was the only interesting nearest relative issue.</p>			<p>o there was the constant tension between challenging him to see.. because potentially it could be a therapeutic thing that he goes, I know the story, like it actually was really dangerous, this is how I'm going to stop doing this in future, and you could actually get somewhere and if you don't give someone the opportunity then it's kind of a fait accompli and you needn't bother interviewing them really because you know what the risks are before you go in.</p>	<p>was hard to imagine what he would have to have said that would have enabled me to think that it was not necessary for his health, safety and protection of others to stay in hospital for further treatment.</p> <p>given what I'd read about him, short of him giving me a narrative of his mental disorder that matched very much that of the establishment and agreeing to [inaudible 0:10:06] medication, which would be a complete change from what he'd been saying the day before so it would be hard to believe that anyway.</p> <p>That feels a bit unfair, almost, asking someone to share their story with you in order that you can assess the situation where what has gone before determines very much what is going to happen, which is fine because that's only part of the assessment</p>	
Participant E	Difficult because person wouldn't answer questions directly- went	When I sectioned him in August he was admitted for 6 weeks. He stayed	his thinking was quite disordered and		His father was the nearest relative and I'd spoken to his father	Quite a difficult assessment as person would not answer		

	<p>off at a tangent or turn question around on you. Wouldn't engage in interview. Walking around room – intimidating. 'It was clear cut'- needed admission. Not demanding to leave but lacked MC</p> <p>When sectioned previously was first presentation- heavy cannabis use since 16- not aggressive-poor academic performance. Might end up having schizophrenia if keeps smoking cannabis- nice pleasant lad, pleasant family- supportive. 'Just cannabis use seems to be really problematic-thinking disordered and paranoid.</p>	<p>on section for 2 weeks- aggressive and they had to restrain and medicate him on admission. After that he radically improved once on anti-psychotics. Was informal for four weeks coming and going- brought cannabis onto ward- destabilised other patients. So if not risk to himself is a risk to others and to staff if they had to restrain him. So there were three sets of risks.</p> <p>He was discharged back to the care of his family in South East London. Started back on cannabis again. Family noticed change in behaviour- agitated, distressed, not sleeping, thinking disordered, he wasn't functioning- couldn't do anything. He thought he was a ninja.</p>	<p>tangential, he couldn't sleep.</p> <p>Although he was cooperative with his mum bringing him to A&E he was getting quite agitated in the A&E. Although he was seeking help, he didn't really have capacity, he was talking about being a ninja, he'd no structured, ordered thinking at all.</p> <p>Difficult because he couldn't manage to engage in answering questions- going off at tangent walked around- intimidating.</p> <p>I think his thinking being so disordered and the fact that he obviously didn't have capacity. I don't think he could even give consistent consent. I think his thinking was jumping every few minutes, he was jumping from different topic to different topic. He couldn't really think in a coherent or structured fashion.</p>		<p>before back in August. Both the parents were supportive of him being admitted back to hospital again, even if it was under the Mental Health Act. I think they were just concerned about the son's presentation. So both the parents, who were quite closely involved in his care, it didn't seem to be a family where there was neglect or emotional abuse or anything like that, it seemed to be quite a warm, cohesive family but they were both supportive of their son being admitted to hospital.</p>	<p>questions in interview. He would go off at tangent and turn questions around and direct them on you. Difficult to conduct interview as he wouldn't engage in process. He would get up and walk around the room. It was clear-cut that he needed to come into hospital. Although he wasn't demanding to leave, he lacked capacity to agree to informal admission.</p>		
Participant F								
Participant G		<p>For a few months has not been collecting his prescription. Gradually started disengaging from the service and his mum who he lives with was suddenly expressing concerns about his behaviour being bizarre, started isolating himself, locking himself in his room, wrapped some clothing around his hand, history of diabetes- allegedly stopped taking physical health meds.</p>	<p>Behaviour being bizarre, started isolating himself, locking himself in room, wrapped clothing around left hand.</p> <p>There are some psychotic symptoms really in terms of people being after him, that his neighbours are planning against him.</p> <p>So there was a persecutory flavour to his thinking at the time. Looks dishevelled.</p>	<p>one I want to speak about, a gentleman who it's known a diagnosis of paranoid schizophrenia, there has been a history of disengagement from services and medication which tends to lead to relapse in mental health.</p>	<p>Need to look at all the circumstances. During the period mum was concerned about him going to hospital. She wanted him treated but was concerned about going to hospital- having a rough deal with police. Police handled things to make everyone feel comfortable</p>	<p>He came downstairs to get involved in the assessment. He was unwell but not floridly. there were some psychotic symptoms – paranoia- there was a persecutory flavour to his thinking at the time. Looked dishevelled hand wrapped in clothing. Asked to have a look at his hand- he refused- said it had nothing to do with his mental health- he didn't seem to be in pain.</p>		

		<p>Things initially started off reasonably OK- engaged with HTT for 4 days then engagement became more erratic. 'Home treatment team would come, he wouldn't open the door, they want me to now get him, I said look let's give him a chance.'</p> <p>Although there is a history of non compliance and admissions to hospital- there is more to his story than that. He hasn't been in hospital for over 6 years. Didn't think CC had been proactive enough- but they told me about efforts they have been making and mum is getting really concerned.</p>	Reluctant to see his GP s still a bit paranoid about blood taking.			<p>During the assessment, probably because he realised that we have the police, there wasn't any... there wasn't any, much resistance from him. Like I said, at the time, though he... there are paranoid and unusual beliefs around him, he wasn't really agitated, aggressive about things and since he actually worked with home treatment team and that was why at the time, even though the doctors were saying that no, he needs to go in. I was saying no, we need to give him the chance. Also, yet at times we need to look at our people, how he appears genuinely frightened about going into hospital. In the end, I thought let's use the less restrictive option.</p>		
Participant H		<p>Following a year of admission to psych ward his OCD was well controlled- within three months of discharge to community symptoms manifested and there was a decline. Not wanting help from family.</p>	<p>within three months of discharge to community symptoms manifested and there was a decline.</p> <p>things appeared to come to a head in the last three months when he was beginning to think that if he had any contact with a woman, there was a possibility that he was going to turn into a woman.</p> <p>He would go to bed wearing the same trainers.</p> <p>his OCD also meant that if he was to complete any activity, for instance preparing to go out, it takes an awful long time to do that, which would include physically leaving the house. It can take up to an hour or</p>	<p>The circumstances of the referral is such that this was a young man who became known to mental health services in the year 2011, when first presented with symptoms of OCD. He was admitted to xxxxxx for a period of up to 12 months, after which he was discharged back into the community</p>				<p>The learning points for me would be in relation to, one, you have to approach every assessment from its own merits. The other learning point in terms of the first one, taking time to go through the full circumstances of any particular assessment, not rushing into an assessment. The other bit is to have an open and honest communication with everyone involved in an assessment process, including family members. Also another learning point is looking at yes, you... I'm so used assessing adults with learning disabilities or older</p>

			<p>more from the time he was fully clothed to going out.</p> <p>There was also continuous risks to women because how he perceived women, he believed if he had anything to do with women he himself will turn into a woman. That's not based in any form of reality</p>					<p>adults equally without learning disability, but also learning point is I was approaching a unique assessment, I needed, one, to draw on my previous knowledge of assessing people in certain circumstance, i.e. someone with either mild, moderate or severe learning disability because it's not your day to day assessment. So I also learned from that, no, before approaching I needed to be aware of their unique needs and how that may or may not impact on the assessment process.</p>
Participant I		<p>Some time last year there was evidence that mental health was deteriorating; verbally aggressive outbursts towards family, totally out of character. HTT brought in- risk of violence could not be managed in the community. She was initially detained under s2</p>	<p>some time last year there was evidence that her mental health was deteriorating in the context of increased verbal and aggressive outbursts towards her husband at home and a few family members, totally out of character</p>	<p>Whilst she remained in hospital, a general adults acute psychiatric ward, she was being looked after and a number of investigations were being carried out because there was suspected possible early onset of dementia.</p> <p>So there was a joint working between the older adults psychiatry and general adults in terms of looking at potential diagnosis of Parkinson's in dementia.</p> <p>Initially, the assessment was carried out by the older psychiatrist was not convinced perhaps that this woman was suffering with Parkinson's in dementia. But the compromise was she'll be admitted to the older psychiatric ward for further examination to be carried out, either</p>		<p>The assessment was undertaken with the patient there, who was able to have some moments of being lucid and being able to give us an account of the circumstances leading to the admission. She clearly presented with auditory visual hallucinations. She was grossly cognitively deficit and again, she showed a lot of evidence of a dementing illness. She couldn't remember where she was, she couldn't remember what day it was, she was able to recall the month, the year she was 10 year apart down what... so she thought we were 10 years to what the current year is. And overall, professionals in attendance were satisfied that actually she was best looked</p>		<p>What complicated the picture further was this lady was also diagnosed as suffering with Parkinson's and apparently there is the correlation in terms of behavioural disturbance of someone who suffers with Parkinson's disease, psychotic episode, behavioural disorders which may mirror that of a dementing illness.</p>

				to allow the dementia or to confront the diagnosis. But the long and short of it was she eventually attracted diagnosis of Parkinson's in dementia with psychosis		after under the Mental Health Act. So I made my application for detention under Section 3 based on the two medical recommendations and the overall circumstances of the case		
Participant J		<p>He had been refusing to take medication, isolating himself, disengaging. The referral came through stating that because of his longstanding history of contact with the MH team- you know that classic remitting and relapsing cycle.- classic kind of disengagement from medication and deterioration in mental state.</p> <p>Lots of stuff was historical rather than current about his present-, about his presentation, so there was lots of disengagement from, from medication, lots of issues around, um, his relationship with his mother, lots of issues about him making some very strange and bizarre, um, comments about AIDS. I'm not sure what that was about. Um, there were a few assaults previously on the ward when he, he had been an inpatient.'</p> <p>Dr asked him a question- he replied "do you have AIDS"? It was incongruent. There was some significance to his past behaviour when he was unwell making those kind of comments.</p>	Had been refusing to take medication- isolating himself and disengaging himself.			<p>Whilst in hospital he hadn't taken any medication. But certainly he wasn't, he wasn't able to tell a kind of, a kind of extended dialogue about his mental health, about things that brought him in there. He wasn't able to explore the various options as to, as to what we could do with him, rather than being a Section 2 whether he was going to stay as an informal patient, um, whether even, even if, if, um, the Mental Capacity Act would apply to him.</p> <p>formed the view that, you know, he wasn't able to understand the information, he wasn't able to weigh, weigh up some of the information we were giving him. And that was evidenced by sometimes when I was trying to talk to him initially about the Mental, Mental Capacity Act ... Mental, Mental Health Act, he kept asking me questions about that, um, and even though we tried different ways of explaining to him he didn't seem to understand it. I think, I think that was an effect of his mental state, I think.</p>		<p>There was, there was some issue about, um, er, about making some threats to neighbours. Um, he had been, he had been in xxxx rehabs, you know, and I ... So I used to work in, in xxxxx so I thought, I thought there was a strong chance that I'd seen him because he'd been there and he'd spent a long period of time there. So I thought maybe I'll link into bridging my relationship with him really so I can relate to him a bit better because I'd probably seen him perhaps and maybe that familiarity will, will help. Um, the doctor that had made the first medical, medical recommendation hadn't had a previous acquaintance with him, and neither had xxxxx, so it was helpful that possibly that I could build on perhaps a previous contact with him. So I was hopeful of that.</p>

		His mother had brought him in because he had stopped his meds and wasn't eating, erratic sleep. So she took him to A&E						
Participant K		<p>She had recently been made redundant. Forced out of her job as a Deputy Head.</p> <p>One of the major issues is that she lost a significant amount of weight. Needed admission to med ward for re-hydration/nutrition. She tried to jump out of the taxi on the way to hospital.</p>	Lost significant amount of weight, tried to jump out of taxi on way to hospital.		Prior to assessment had conversation with NR-dtr- they expressed concerns that she needed to be in hospital and needed to be there for a period of time to get treatment. They weren't able to look after her in the daytime when they were at work.			
Participant L	I checked all the notes. That's what I usually do before I go out. I check, um, the computer system we have to see any kind of, any other services that may be involved, and this gentleman was known to neurology service, so when he was seen he actually was okay in his presentation, but his wife wasn't in the, didn't go into the session.	It was clear that there had been a gradual decline because he stopped having his depot- the following year he stopped his depot.	<p>I think team lost communication with him, so now they were trying to, um, start him back on the depot, because he'd missed one and he'd gradually declined, so the, but the wife was concerned because he was becoming irritable and shouting at the family, and he wasn't saying things that made any sense.</p> <p>he was extremely thought disordered, um, and that's where I was thinking this man, you know, it's quite terrible, you hear in all sorts of the media and y you just hear all these stories where people were saying all sorts of things, and they weren't taken seriously, and you don't know, like I say, the unpredictability, I'm not quite sure what you could have done.</p> <p>Wife worried about being left on her own with him- he had threatened her in 'a psychotic context'-so</p>			<p>I attended with one s12 dr and two police officers. We called through the letterbox and he shouted at us to go away. Warrant was used to gain entry – he didn't want us there. Usually warrant used to remove someone to place of safety but that is a last resort. he was telling us to get out, he wasn't talking, um, he was just shouting at us, he was shouting things that didn't make sense. I can't remember the content now, but it, it, it was, it was more deluded content and, and shouting, and he was quite rigid in his, where he sat</p> <p>I think the decision was based on the fact that he could not engage with us. He could not form any, any kind of conversation about his illness. He would just make comments like "kill me, kill me", um, "kill yourselves", um, you know.</p>		

			<p>she's unsure if he, he hasn't actually, he didn't, he hadn't hit her, but she was concerned, she didn't know what he was doing, he's unpredictable.</p> <p>So I had a risky situation presented by wife. She is his carer- think sometimes carers have difficult time in trying to access services. They can struggle to get in because people don't always take them seriously- people think they're exaggerating. I think when it gets to this level of MHAA it's serious and we need to consider seriously what family are saying. They're in a risky situation and we need to look at it and see how those risks need to be managed.</p>			<p>And a lot of the time it depends on the person's understanding about their illness. That's I think my pri-, that's how I, um, make my decisions a lot of the time. What do they understand about their situation and what's happening? Do they understand that people are concerned about their behaviour?</p>		
Participant K	<p>Referral for a younger person. Not much information. Read that young person had "very advanced thinking"</p>	<p>Fortunately she didn't end her life- she told her mum- the next day they contacted MH team. Ended up being brought to A&E and ended up being seen there.</p> <p>Reading her notes it wasn't the first time she done something to herself. She'd harmed herself the year before. She's taken a large OD- 30 paracetamol- was seen at A&E that time again.</p> <p>Under MH team- not sure whatthey do wither. Some issues around her weight.</p> <p>'History's very important, I think, particularly with risk, so this is a young person that we needed to really establish what her risk was to herself.'</p>	<p>She tied a ligature around her neck. Tried to strangle herself to extent where she had caused herself bruising and stressed herself.</p>			<p>Doubts whether she has insight. Unable to see a problem despite wanting to kill herself- not willing to even have a conversation about hospital admission</p> <p>You know, we spoke to her about possibly eating disorder that she might have and that might need further exploration; depression that she seems to, she was, you know, very flat, poor eye contact, didn't really um, look directly at us, a lot of the time her body was away from us. Um, she shrugged her shoulders a lot. There was a lot there that you knew this was a very distressed young woman, but she, she, or young girl, but she saw it differently.</p>		

						<p>She, she was not willing to even really consider hospital, so, so I did that bit and then ended the interview, Doctor xxxx and I then spo-, had a discussion, and um, asked him his opinion in regards to mental disorder. So he felt that she had depression and I, I felt she had some form of eating disorder traits, um, and we both agreed that she did need some assessment to look at treatment, um, and just some maybe therapeutic, more intense kind of, cos she had outpa-, she had xxxx, but something wasn't working there, some approach wasn't working for her.</p> <p>And then um, so there's risk to herself. She also wasn't able to convince us that she had much insight into her problem, her psychological difficulties, um, mental disorder, so that then I think would increase risks further. xxxxx isn't helping. She's struggling with her relationship with her family because they, you know, they don't know how to help her.</p>		

Chart 3 Understanding the individual