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Changing Gears and Buying Time: A Study Exploring AMHP Practice Following Referral for a Mental Health Act Assessment in England and Wales

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Abstract

The role of the Approved Mental Health Professional (AMHP) under the Mental Health Act (MHA) 1983 in England and Wales is to respond to referrals for psychiatric detention and make an application for detention where they consider this necessary. This article reports the findings of my doctoral study into AMHP decision-making at the point of referral for an MHA assessment. The strengths-based methodology of Appreciative Inquiry was adopted, positioned in a social constructionist paradigm. Nine AMHPs working for one Local Authority participated in the study, including myself as an insider researcher. During four one-day workshops over five months participants defined their best practice, analysing emerging data together within the workshops using nominal group technique. Service developments included the creation of a triage role and a bespoke report to prioritise this decision within the service, opening avenues to *change gears and buy time* for a more thorough assessment at this point, and promoting greater collaboration with those referred. A multi-agency approach to searching for less restrictive options was advocated within an assessment pathway. The results of this study offer a research insight into this important area of practice, offering an evidence base to inform practice and policy developments.

Keywords: AMHP, appreciative inquiry, decision-making, Mental Health Act

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Introduction

The Mental Health Act (MHA) 1983 is a legal framework that legitimises enforced psychiatric inpatient treatment in England and Wales. Rates of detention are increasing (NHS Digital, 2022), something the government are seeking to address through the MHA review (Department of Health and Social Care (DHSC), 2022). The civil elements of this legislation are enacted by Approved Mental Health Professionals (AMHPs) (formerly Approved Social Workers (ASWs)) who are responsible for making applications to detain people in hospital, even when this may be against their will, under certain circumstances and usually subject to two medical recommendations. Applications for detention are generally made following an MHA assessment. Such an assessment usually involves two doctors as defined under section 12 Mental Health Act 1983: a doctor with previous acquaintance if possible; a doctor approved under section 12(2) MHA 1983 with specialist knowledge in treating mental disorder, two section 12(2) approved doctors if the former doctor with previous acquaintance cannot be achieved. These two doctors and an AMHP all interview the person, though not necessarily together. The doctors involved decide whether to make medical recommendations subject to a set of criteria defined in section 2(2) or section 3(2) MHA 1983 and based on their own professional judgement. The AMHP, if provided with two medical recommendations, makes a wider decision about whether detention is required 'in all the circumstances of the case' (MHA, 1983, section 13(2)).

The assessment process is co-ordinated by the AMHP (Department of Health (DoH), 2015, chapter 14.41), who in the first instance receives some form of referral from a third party. Both the referral for an MHA assessment and the assessment itself are nebulous concepts. There is no definition in law or statutory guidance about either concept, yet in practice there is a socially constructed reality that enables those professionals involved in the process to enact this aspect of mental health law in England and Wales.

Broadly speaking a referral is construed in practice as some form of communication with an AMHP from another party, usually another professional or a family member, where a request is made to the AMHP for an assessment to be considered. This understanding of the point of referral is underpinned in law in section 13(1) MHA 1983 whereby an AMHP must 'consider the patients case' where they have 'reason to think that an application… may need to be made'. The assessment is then considered to be the coming together of the AMHP, two doctors as defined in section 12 MHA 1983, and the person referred for an 'interview' (MHA, 1983, section 13(2)). This interview is an AMHP responsibility prior to making an application for detention, with doctors being required under section 12(1) MHA 1983 to have 'personally

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examined' the patient prior to making a recommendation for detention, but the merging of these legal responsibilities in an assessment interview has occurred in practice, creating the social construct of the MHA assessment as a one-off event. An AMHP may decide not to arrange an assessment interview with doctors following a referral, yet decision-making at this point is hidden. It is rarely mentioned in peer-reviewed research, and there is no statutory guidance issued to AMHPs about how to navigate this mysterious terrain. The complexity of AMHP decision-making is attracting attention (Hemmington and Vicary, 2023) with this article offering a complementary perspective focussed on the point of referral for an MHA assessment.

Decision-making at the point of referral for an MHA assessment is crucial when considering how the assessment interview with doctors can be traumatic (Brammer, 2020; Rooke, 2020; Blakley *et al.*, 2022), and experienced as procedural (Grace, 2015). Indeed, the result of assessment interviews with doctors is usually detention (Wickersham *et al.*, 2020; Davidson *et al.*, 2021). The current MHA review in England and Wales provides an impetus for change, with a desire to address rising rates of detention (NHS Digital, 2022), and AMHP decision-making at the point of referral providing an unexplored avenue to achieve this.

AMHP services are usually structured in a way that relies upon the swift transition from referral to an assessment interview with doctors (or diverting away from this) because AMHP duty systems often rely on workflow that can be started and completed by the same AMHP, usually the same day. A socially constructed reality has been created of the MHA assessment being a one-off interview with the person referred, with this activity being prioritised in the service. There will be exceptions to this statement, but this supposition will be recognised by professionals in the field. In his doctoral study, Abbott (2018) found assessments were completed on the same day as the referral, echoed by Fish (2022) in her opinion piece about the loss of the social perspective.

Literature

There is limited reference to decision-making at the point of referral for an MHA assessment in the available literature, highlighting an absence of research focused on this area of practice. To explore decision-making at this stage, I searched for peer-reviewed literature in relation to ASW/AMHP detention decisions (Simpson, 2020, 2023) drawing out references to decision-making at the point of referral for an MHA assessment from those sources. The following search terms were applied: 'Approved mental health pr*' OR 'approved social work*' AND TI/AB 'decision making' OR decision-making OR deciding OR decision# OR uncertainty OR risk OR experience# OR complexit*.

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Quirk *et al.* (2003) researched ASW detention decisions and referred to ASWs visiting people referred as a means of delaying an assessment, suggesting this visit is not an assessment. Glover-Thomas (2011) similarly described actions taken by the AMHP before an assessment with doctors as outside a legal framework. In Quirk's (2007) later thesis expanding upon his earlier paper, he described such investigations as informal. Quirk (2007) also made the point that these investigations can sometimes lead to the assessment being cancelled. Such perspectives appear to delegitimise AMHP decision-making at the point of referral for an MHA assessment.

Thompson (1997) included reflections on a practice example where he responded to a referral for an MHA assessment by visiting the service user and then deciding not to proceed to a further assessment interview with doctors. Crucially, Thompson (1997) concluded this was an MHA 1983 assessment. Subsequently, Thompson (2003) reflected on another experience of an ASW responding to a referral by assessing the person referred alone, concluding detention was not merited. Thompson (1997) and Thompson (2003) highlight that ASWs carried out an assessment following referral that did not necessarily include doctors, standing in contrast to a definition of such assessments as informal (Quirk *et al.*, 2003; Quirk, 2007; Glover-Thomas, 2011).

In his doctoral study about the use of the law in AMHP practice, Abbott (2018) explicitly referred to the point of referral for an MHA assessment, however, he described it as a preliminary to an assessment with doctors. In Abbott's study all AMHP participants discussed an assessment which led to a decision to detain, offering some context to Abbott's (2018) correlation between referral and assessment.

In his doctoral study Brammer (2020) considered decisions were made at the point of referral for an MHA assessment, but much like Quirk (2007) and Glover-Thomas (2011) he situated this decision outside the MHA 1983, albeit he found a significant consideration was whether the AMHP believed the criteria for detention would be met (Brammer, 2020). Wickersham *et al.* (2020, p.655) described such decision-making as 'rigorous referral screening'.

In her opinion piece Rooke (2020) explored decision-making at the point of referral for an MHA assessment, specifically locating her recommendation to meet the person referred within section 13(1) MHA 1983, further extending the legal basis to include section 115 MHA 1983 which is a power of entry and inspection due to welfare concerns provided the resident does not object. Rooke (2020) viewed such a meeting as a form of early intervention in situations of low risk. Her perspective aligns most closely with the assessments described by Thompson (1997) and Thompson (2003).

The statutory context of decision-making at the point of referral is recognised by some authors (Thompson, 1997, 2003; Rooke, 2020) but not

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others (Quirk *et al.*, 2003; Quirk, 2007; Glover-Thomas, 2011; Abbott, 2018; Brammer, 2020; Wickersham *et al.*, 2020). Such limited insights into the decision at the point of referral for an MHA assessment highlighted a significant gap in the literature that justified further research to illuminate this experience.

Methodology

This article is written in the first person because of my position as an insider researcher and participant. As a Local Authority AMHP Lead I was fascinated by how there was no prior research into decision-making at the point of referral for an MHA assessment. I found this area of practice complex, and yet there was no guidance on how to approach it. The aims of this study were:

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

I adopted the strengths-based methodology of Appreciative Inquiry, a qualitative research methodology from an interpretive paradigm, accepting a world of multiple realities. Much of the Appreciative Inquiry literature relates to organisational development, but it was first developed by David Cooperrider as a health research methodology (Cooperrider and Srivastva, 1987). Liebling *et al.* (1999) researched prisoner and prison officer relationships using Appreciative Inquiry, and I immediately saw a parallel. AMHPs practise within a context that brings them criticism based on the nature of decisions that are destined to always be unacceptable to someone (Campbell, 2010). Stanford (2011) found social workers feared criticism and so were cautious about discussing their practice, a position I felt could equally apply to AMHPs. The rationale for utilising Appreciative Inquiry for Liebling *et al.* (1999) was to counterbalance the negative perspective about prison officers and therefore promote greater engagement in the research process. I could see the same applying to AMHPs, with a methodology founded upon strengths more likely to bring the best out of participants and lead to tangible positive outcomes.

Appreciative Inquiry is founded upon a set of five principles, offering the best way to conceptualise the methodology. To summarise, Appreciative Inquiry is founded upon social constructionism, accepting a world of multiple realities where meaning is created amongst groups through conversation

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(Berger and Luckman, 1966). Simultaneity is where focussing discussion on a topic starts to change it (Whitney and Trosten-Bloom, 2010). The poetic principle relates to the choice of what to study and how this creates what we discover (Whitney and Trosten-Bloom, 2010). The anticipatory principle relates to how positive future images can impact on current practice positively (Whitney and Trosten-Bloom, 2010). The positive principle is based on the belief that positive outcomes are more likely to arise from a positive focus (Whitney and Trosten-Bloom, 2010), but also that people engage more deeply and are more interested in positive ideas (Reed, 2007). These principles shape an Appreciative Inquiry without prescribing a specific research process.

Appreciative Inquiry is fundamentally about change. As such pragmatism offers an aligned philosophical perspective that does not seek to define reality, rather the focus is on what use can be made of knowledge: inquiry is judged by its application to practice (Reed, 2007). Koopman (2006) clarified that from a pluralist position of multiple realities, and a humanist position that humans can contribute to forming these realities, philosophical hopefulness, or meliorism, combines in pragmatism to conclude that we can create better worlds for ourselves democratically. This merging of pragmatism with hopefulness is compelling in its optimism about the future. This speaks directly to the essence of what I hope this study has achieved: the dual benefits of understanding alongside enhanced practice outcomes for the future.

Participants

Ethical approval was sought from the Bournemouth University ethics board, and this was approved on 3 December 2019 (Ethics ID 27945). The relevant local authority then additionally approved the study on 21 January 2020. Ethics approval was amended and approved twice further during the study (15 July 2020 and 5 November 2020) in response to the study taking place during the coronavirus pandemic. The first amendment was to approve the study going ahead face-to-face during the pandemic with COVID security measures in place. Participants had been given the option for online, but their preference was face-to-face, enabling the first two workshops to proceed in person, albeit delayed by six months. The second amendment was to move the study to an online platform during a period of national lockdown, something the participants wanted rather than delaying the conclusion of the study. Aside from the initial delay to the workshops and the conclusion online, the pandemic did not adversely impact the study. Participants engaged well in the strengths-based approach, appreciating the chance to get together during a time where social contact had become limited.

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Appreciative Inquiries address an organisational change agenda, using the 4-D cycle (discovery, dream, design, and destiny) to design and implement positive change (Whitney and Trosten-Bloom, 2010). The focus on change brought the scope of the study into the organisational level, where a shift in local policy and practice norms was achievable. As a result, this study sought to include practising AMHPs from one local authority in England.

Group characteristic sampling strategy was advocated by Patton (2015), the selection of participants with relevant experience to enhance the data. One such strategy is a complete target population (Patton, 2015). In this study such a strategy would have involved including all sixteen AMHPs employed by the local authority. However, adhering to both research ethics and the Appreciative Inquiry principle of free choice participants were given the option to decline participating. In this way the sampling strategy of complete target population of sixteen became the initial intention, recognising that the final sample would be self-selecting from the target population (Hughes, 2011).

Recruiting participants was facilitated by the trusting relationships I had established in practice. As a practising AMHP I knew I would influence the results of this study, and so for transparency I became a participant. Nine participants, including myself, agreed to take part in this study after being provided with participant information, all signing a consent form, and each giving themselves a pseudonym (see Table 1). All participants were between forty-one and seventy years old. This is a slightly older demographic than has been recorded nationally where 74 per cent of AMHPs fall into the forty plus age range (Skills for Care SfC, 2022). All participants were white British compared to 80 per cent nationally (SfC, 2022). Sixty-six per cent were female compared to 74 per cent nationally (SfC, 2022). Seventy-seven per cent had over eleven years' experience working as an AMHP. This is a much higher level of experience than a comparable measure of the duration of

Table 1. Participants.

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

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experience of AMHPs in the adult social care sector nationally, where only 29 per cent had over ten years' experience (SfC, 2022). Eighty nine per cent were social workers compared to 95 per cent nationally (SfC, 2022).

Methods

The main cyclical process developed to shape an Appreciative Inquiry is the 4D cycle (Whitney and Trosten-Bloom, 2010). Viewed as guidelines this cycle offers a tangible insight into what might constitute an Appreciative Inquiry without the prerequisite that it must be rigidly followed.

The research method was group-based, the term 'workshop' in common use in my work setting as a space for reflective learning. Workshops gather people with experience in a particular area (Ørngreen and Levinsen, 2017). Like Appreciative Inquiry this method is founded upon social constructionism because the conversation is of primary importance; reality is constructed between the participants and researcher alike (Ørngreen and Levinsen, 2017).

This Appreciative Inquiry comprised four one-day workshops, with the same nine participants working through the full 4D cycle based on tools and methods described by Whitney and Trosten-Bloom (2010) (Figure 1).

Data analysis was completed within the workshops by participants using nominal group technique, a structured form of group-based decision-making (Van de Ven and Delbecq, 1974).

Findings

Discovery

In Appreciative Inquiry the focus of the research is decided upon by participants rather than the researcher, termed affirmative topic choice (Cooperrider and Whitney, 2005). Whilst the area of practice was pre-defined (Reed, 2007), the way in which the interview questions for the discovery phase were developed was based on the aspects of practice that participants wanted to see emphasised (Whitney and Trosten-Bloom, 2010). Mini interviews were used to generate the themes from which the appreciative interview questions were developed. Mini interview questions were adapted to the AMHP context but based on a generic interview schedule developed by Whitney and Trosten-Bloom (2010). The questions were designed to give participants an experience of using positive questions, with conversation being central, creating inspiring stories about best practice (Whitney and Trosten-Bloom, 2010).

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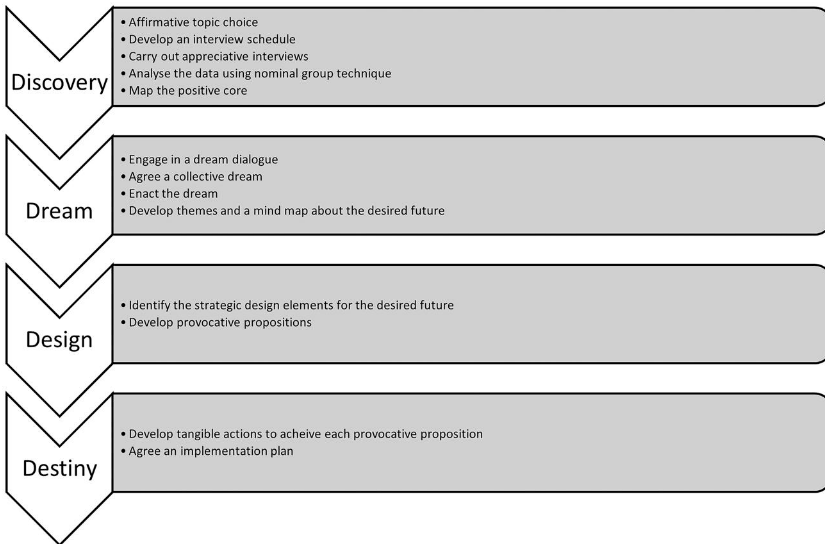

Figure 1: Appreciative Inquiry process.

I chose to use this interview schedule because of its simplicity and direct adherence to the core principles of Appreciative Inquiry. Paired participants interviewed each other, considered key messages individually and then discussed these in their pairs, followed by small groups and then the whole group. The themes agreed may be summarised by viewing the person and a holistic understanding of their lived experience as central. The AMHP using their knowledge, experience, and awareness of alternatives to work collaboratively with the person referred. Being analytical, and issues of risk and time emerged, these concepts relating back to the AMHP and their knowledge and experience. What looked like seven themes appeared to be grouped in three interconnected meta-themes, the person referred between the AMHP and risk, the AMHP drawing on their experience and knowledge to analyse risk and try to *buy time*.

Appreciative interview questions were developed by participants based on the themes identified, seeking to encourage a positive generative narrative (Whitney and Trosten-Bloom, 2010). Participants interviewed each other having collectively decided not to broaden data collection to other participants outside the workshop group based on a concern others may not embrace the positive emphasis. Figure 2 depicts the themes identified with examples.

Combining the data from the mini interviews and appreciative interviews, a clear process of assessment is inferred, underpinned by a desire to slow down, and create the space to fully consider the relevant factors surrounding the person referred.

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Theme	Example
Experience (professional, personal, expertise) leading to intuition and confidence	*after many years working in mental health you know when to do [an] MHA assessment* (Jean)
Peer/Team support as a resource	*moral support in an otherwise hostile environment* (Jake)
Support from partner agencies	*focus on the person and not team dynamics* (Charlie)
Focus on essence and uniqueness (identity) of person	*as a person… with a life… strengths based not deficit based* (Sián)
Listening to the person and others	*people are experts in themselves* (Frank)
Transparency	*sometimes people are taken unawares [about] concerns and this is worrying* (Sián)
Focus on social perspectives	*Looking at context* (Jake)
Seeing people through different lenses	*look[ing] at individual[s] through different lenses; medical, psychosocial, psychodynamic* (Frank)
Balanced view of outcomes	*the impact this request could or would have for the patient* (John)
Open to all possibilities	*Knowing [I am] not always right [and] not fall[ing] into [the] trap of [thinking I have] seen this before. Things are never the same* (Frank)
Collaboration with services/family	*sharing not abdicating responsibility* (Sián)
Shared understanding with the person	*valuing people are experts in themselves* (Frank)
Joint visit	*listening to [the person's] wishes and feelings* (Jake)
Documentation/opinion subject to verification	*views can be distorted* (Charlie)
Analysis of risk/protective factors	*analyse rather than accept at face value* (Sián)
Acceptance/tolerance of risk/positive risk taking	*sometimes risk is part of who the person is (Frank).* *proportionate* (Edie)
Changing gears and buying time	*slow it down and buy time to properly look at the circumstances* (Jake)

Figure 2: Appreciative interview themes and examples.

The culmination of the discovery phase was the illustration or mapping of the positive core (Whitney and Trosten-Bloom, 2010). The study up to this point had been about recognising participants' best practice now regarding AMHP decisions at the point of referral for an MHA assessment, with this positive core map seeking to visually represent how participants conceptualise their practice in relation to this decision (Figure 3).

The positive core map emphasises both person-centred practice and the value participants placed in connecting with the person referred. The notion of the AMHP trying to change gears and buy time features prominently. This positive core map, together with key messages from the appreciative interviews, highlights the importance of time for information gathering,

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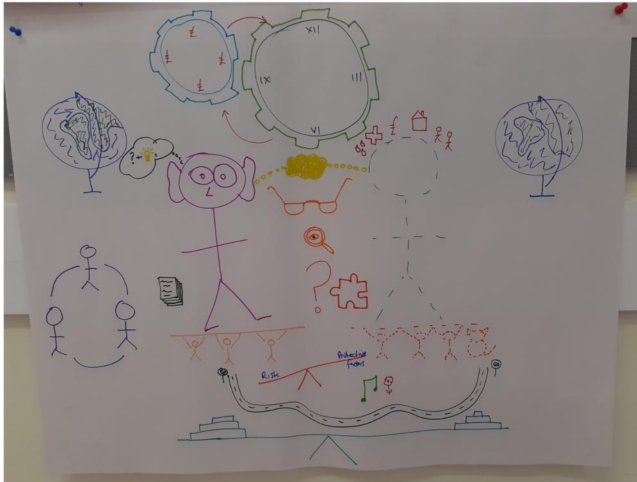

Figure 3: Positive core map.

analysis and exploring alternatives, all linked to meeting the person referred and by extension raising risk thresholds and improving clarity.

Dream

Appreciative Inquiry dreaming in this study began with defining a collective dream, achieved through individually considering a focal question about a future practice ideal adapted from Whitney and Trosten-Bloom (2010) and then clarifying this collective dream as a group. Key elements included the identification of a graded pathway following referral, a formalisation of what participants saw themselves trying to achieve now, but the desire was for this to be accepted by other agencies as part of the process, rather than current practice where participants were trying to achieve this against a pressure to make decisions quickly.

Borrowing from the blue light protocol in learning disability services (NHS England, 2015), the inclusion of a *blue light* meeting in the process emerged in the appreciative interviews and collective dream as a way of sharing decisions and collaborating with other services to prevent the need for admission. Participants felt that learning disability services, who already use blue light meetings to engage stakeholders and commissioners to find alternatives to admission, have acknowledged that admission is something to be avoided as far as possible, but mental health services do not share this view despite the principle of least restriction (DoH, 2015, chapter 1.1). Participants wanted to see mental health services taking a more holistic view of people's needs rather than focussing on admission and medical treatments.

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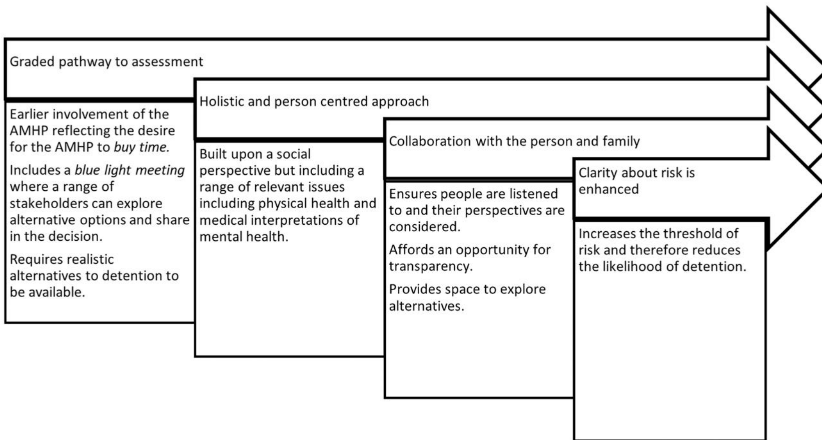

Figure 4: New knowledge from the dream stage.

We enacted the collective dream in the form of a blue light meeting based on a real case example, after which we created a mind map of the desired future. Combining the dream and discovery stages some key messages emerged about the way AMHPs in this study saw AMHP services operating in the future (Figure 4).

Design

In the design phase of this Appreciative Inquiry participants identified strategic design elements such as policies, procedures, and accepted working practices that impacted upon achieving the desired future, following which provocative propositions were developed for each design element. The design elements included the process of triaging referrals, continuity of response, and services working together. Provocative propositions are expressed as a future ideal that already exists; they are based on best practice as identified in the discovery phase; they stretch practice beyond what is currently achieved; and they move practice to where they want it to be (Whitney and Trosten-Bloom, 2010).

Destiny

In the destiny phase participants developed tangible actions to achieve the desired future. Key elements included the development of a *triage AMHP* role, facilitating multi-agency collaboration aligned with blue light meetings, and the development of a new report to capture any actions carried out by the *triage AMHP*, including any thoughts on what should happen next. This report, termed the *AMHP* section *13.1 report*,

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was in response to acknowledging the importance of the decision at the point of referral for an MHA assessment, this decision being incorporated in section 13(1) MHA 1983.

Discussion

Emphasising section 13(1)

This Appreciative Inquiry has drawn attention to how AMHP participants in this study explore a myriad of issues prior to convening an assessment interview with doctors when they are practising at their best. Traditionally, an MHA assessment has come to be conceptualised as a one-off interview involving two doctors and an AMHP, although this is not defined in law or practice guidance. The requirement to involve doctors in MHA processes, is to provide the necessary medical opinion and recommendations upon which an application for detention may be founded (MHA, 1983, section 2 (2)). The AMHP role is to explore the social perspective, applying the principle of least restriction and considering alternative options (DoH, 2015, chapter 14.52). Blakley *et al.* (2022) researched service user experiences of the MHA assessment interview and highlighted how this is not achieved when all three professionals are present, leaving those subject to the assessment feeling peripheral to the decision and disempowered.

The divergence from traditionally accepted MHA assessment processes identified in this study, emphasises the importance of the AMHP role at the point of referral for an MHA assessment, for it is at this point AMHPs in this study have identified they are more able to achieve the intention of their role than at any other time. The importance of this is highlighted by some studies that have found detention is the most likely outcome of assessments convened with doctors (Wickersham *et al.*, 2020; Davidson *et al.*, 2021). Fish (2022) thoughtfully challenged the way AMHPs may have become complicit in rising detention rates through the loss of the social perspective. This could be a function of the way in which assessments are organised. In the strive to reduce detentions, section 13(1) MHA 1983 may represent a key opportunity to redress this and reclaim fundamental aspects of the AMHP role, returning to practice similar to that described by Thompson (1997) and Thompson (2003) in relation to the ASW role.

The implication from this study is that, prior to organising an assessment interview that includes doctors, AMHPs should ensure that they have satisfied themselves that they would make an application for detention if provided with medical recommendations. Brammer (2020) found something similar in that AMHPs in his study wanted to establish an opinion about whether the person met the grounds for detention prior to involving doctors, however, this was more about the potential rather than forming a definitive opinion based on an assessment of the person.

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AMHPs in this study described an intricate process of assessment they follow to reach such a conclusion, when they are practising at their best. The sense of optimism about avoiding detention through their intervention at this stage, particularly when the AMHP has created the opportunity to meet with the person referred, stands in stark contrast to the lack of optimism about the outcomes following an assessment interview with doctors, where a lack of alternative options may become decisive (Quirk *et al.*, 2003; Bonnet and Moran, 2020). This optimism borne out of a personal connection was also identified by Pooler *et al.* (2014) in their study into joy in social work. AMHPs in this study, when considering the point of referral, were optimistic about finding alternatives to detention.

AMHP triage in a statutory context

Conceptualising AMHP decision-making at the point of referral for an MHA assessment as a screening process, where referrals may be rejected based on simplified variables, reduces the decision, displacing responsibility back to the person making the referral. This has previously been referred to as a non-legal or informal process (Quirk *et al.*, 2003; Quirk, 2007; Glover-Thomas, 2011; Brammer, 2020), reduced from assessment to screening (Wickersham *et al.*, 2020). Rooke (2020) sought to counter this in her opinion piece, situating a visit to the person referred within section 115 MHA 1983, a power invested in an AMHP to enter someone's home where there are concerns about their mental health and welfare. She also described this visit as part of section 13(1) MHA 1983, but only in an early intervention context where risks are assessed as low (Rooke, 2020). This Appreciative Inquiry has firmly established an assessment at the point of referral for an MHA assessment within section 13(1) MHA 1983, much like Rooke (2020), although applied more broadly to all referrals not just those made as part of an early intervention strategy. Recognising the statutory basis of this assessment and defining it as the MHA assessment itself may be a return to the ASW practice described by Thompson (1997) and Thompson (2003).

This is the enactment of section 13(1) MHA 1983 in its richest sense, where the AMHP is tasked to 'consider the patient's case' and from this study does so thoroughly and inclusively prior to reaching any conclusions about involving doctors in a more oppressive assessment interview with doctors destined for a detention decision. The trajectory towards detention has scope to be diverted at this point. The *triage AMHP* role and *AMHP* section *13.1 report* were developed as part of this study to recognise that such assessment activity requires the investment of time that might be lost in services that prioritise traditional one-off assessment interview approaches.

This finding prompts a reconsideration of how MHA assessments are understood in practice, locating the MHA assessment within the actions

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taken by the AMHP under section 13(1) MHA 1983 rather than a one-off interview with an AMHP and doctors.

Risk perception

Risk was evinced by Kinney (2009) as key to the AMHP role, and for participants in this Appreciative Inquiry risk factors are critically analysed by the AMHP at the point of referral for an MHA assessment, with the harms of admission included in the balance. Brammer (2020) equally supported this finding in his doctoral study of AMHP decision-making. Additionally, AMHPs have a higher threshold for risk, promoting positive risks to achieve collaborative aims (Brammer, 2020). Risk was identified as critical in detention decisions (Sheppard, 1990; Glover-Thomas, 2011; Stone, 2017; Brammer, 2020; Karban *et al.*, 2021) and the point of referral for an MHA assessment represents a crisis where risk factors have become intolerable for the referrer (Abbott, 2022). Thompson (2003) considered the crisis as a turning point where things can either get worse or get better, and Blakley *et al.* (2022) have highlighted how in a one-off MHA assessment interview it is usually the former. Achieving their core function at the point of referral for an MHA assessment is a significant finding in relation to AMHP practice, as it raises the importance of this neglected area of practice, situating the key to successful AMHP practice in section 13(1) MHA 1983 decision-making. This is a striking finding given the paucity of attention paid to this aspect of AMHP practice in both research and guidance and given many AMHP services have not created systems that adequately reflect the value of this decision.

Countering risk aversion

AMHPs in this study identified their best practice as being able to analyse the identified risk factors which they felt were often overinflated by the referrer. This finding is supported by Regehr *et al.* (2022), who carried out a study into crisis decision-making in a mental health context, finding emotionally driven risk decisions focus on threat stimuli, and identifying an emphasis on a more analytical approach. Equally Saltiel (2016) found decisions made by child protection social workers were more likely to include errors when made quickly. The independent MHA review reported risk aversion is prevalent in mental health services (Department of Health and Social Care (DHSC), 2018) providing rationale for why Abbott (2022) argued in his later published paper arising from his doctoral thesis for AMHPs to adopt a rights-based approach. This key emphasis of AMHP practice, together with an analytical approach, may enable AMHPs to

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achieve their best practice through collaboration, transparency, and often a connection with the person referred.

Changing gears and buying time

Changing gears buys time to gain clarity and work collaboratively with the person and others to explore alternatives. It is striking to consider the organisational systems that may prevent the opportunity for AMHPs to achieve these goals at the point of referral, for Blakley *et al.* (2022) highlighted how these ideals are not achieved when AMHPs are joined by doctors for a traditional assessment interview. The emphasis of time created is to promote a personal connection, work collaboratively and transparently with the person and others, and through this graded pathway create opportunity for a different outcome. This produces a service imperative to design systems that enable AMHPs to dedicate their time to this process of assessment and decision-making at the point of referral, where meeting the person referred may form an essential element of achieving less restrictive practice.

Limitations

This study has focussed on the participants' definition of their best practice, and within this there may be acknowledgement that this was not always achieved. This is the inevitable shadow created by such a focus (Fitzgerald *et al.*, 2010), but rather than dwell on problems participants pragmatically addressed some of the organisational challenges to achieving their goals through the development and implementation of service design elements, socially reconstructing a better future. This has been the first study into AMHP decision-making at the point of referral for an MHA assessment. The perspective of nine AMHPs in one Local Authority area when they are practising at their best has been established. Further research in other geographical areas would help ascertain the degree to which AMHPs collectively share the same perception of best practice. Future studies may consider other stakeholder views, in particular the views of those who have been the subject of these considerations.

Conclusion

Rather than the pressure at the point of referral (Abbott, 2018; Rooke, 2020) leading to the triggering of a reactive one-off MHA assessment interview that involves doctors and likely detention (Wickersham *et al.*, 2020; Davidson *et al.*, 2021), AMHPs in this study felt that when they are practising at their best they critically analyse risk. They do this within the context of a higher level of risk tolerance, built upon their experience and validated

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by their peers. Often participants felt the result of this analysis is the ability to slow down the process, and a graded pathway can be created where AMHPs begin to collaborate with the person referred, their family, and other services. At this point the core aspects of AMHP practice can be achieved where transparency and co-construction can lead to a reality that opens avenues to less restrictive alternatives to detention. Considering the outcomes from Blakley *et al.* (2022), practising in this way is likely to improve the experience of the assessment process for those subject to it, as well as enhance the prospect of less restrictive outcomes.

Creating graded pathways in MHA assessments promotes a sharing of responsibility for finding viable alternatives to detention, providing an opportunity to counter the current trend of risk aversion within mental health services (DHSC, 2018). Services that value the role of the AMHP at the point of referral for an MHA assessment will promote systems and a culture that will support and encourage AMHPs to seek to slow the trajectory towards detention and create the necessary time to explore alternative options collaboratively without involving doctors in an oppressive interview process.

This study has cast the shadow of how the simplistic screening of MHA assessment referrals, followed by a one-off MHA assessment interview may not enhance the best AMHP practice. Learning from the best AMHP practice described in this study might see reconceptualising traditional MHA assessment processes to encompass thorough and collaborative assessment at the point of referral within the legal horizon of section 13(1) MHA 1983.

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