University of Kent | School of Social Policy, Sociology and Social Research

Exploring the role of Approved Mental Health Professionals in relation to the detention of people from Black and Minority Ethnic groups under the Mental Health Act (MHA) 1983.

Peter Kwaku Baffoe

Thesis submitted for the degree of Doctor of Philosophy (PhD) in Applied Health to the School of Social Policy, Sociology and Social Research (SSPSSR), University of Kent (2024).

Word Count: 76861

Abstract

Persistent inequalities in mental healthcare have contributed to the over-representation of people from Black and Minority Ethnic (BME) groups being assessed under the MHA. This was reinforced as recently as 2018 by the Independent Review of the Mental Health Act 1983, detailing how BME communities - especially people with African and Caribbean heritage - are less likely to receive person-centred or community-based social care, and likelier to be compulsorily admitted to psychiatric hospitals than white people. Despite the longstanding nature of the problem, little has been researched about the role of one of the two key professionals responsible for decision-making about compulsory admission: the Approved Mental Health Professional (AMHP). Under the Mental Health Act, AMHPs possess overriding responsibility for deciding whether someone should be detained for compulsory treatment. While the institutional dimensions of this problem have been highlighted in earlier research, this thesis focuses on the use of power and discretion in AMHP decision-making.

This research's objectives were to explore the key influences professionals consider when forming judgements about compulsory detention, to examine how practitioners construct risk when arriving at a decision, and to investigate the views and accounts of Black service users concerning their detention experiences, and their level of involvement or participation in decisions determining their care and treatment.

This thesis employs empirical data from an ethnographic study conducted in two London Boroughs, involving observations of professional practice and follow-up interviews with 14 AMHPs and 8 Black service users purposively selected across the two sites. Fricker's theory of epistemic injustice and the applied sociological concept

of risk work provided a useful theoretical basis for developing an understanding of AMHP decision-making and Black service users' detention experiences.

My analysis reveals a mutually constitutive relationship between risk and ethnicity during detention-based decision-making, describing the racialised categorisation of risk, and how AMHP decision-making continues to be shaped by a risk or public safety agenda. The analysis of my observational data generated a nuanced and complex relationship between the diagnostic practices and lower risk threshold operationalised by professionals when working with Black people. This thesis demonstrates the tensions emanating from risk work and suggests that the bureaucratic emphasis on risk management strategies designed to improve safety is paradoxically affecting trust and relationship-based practice, both of which are essential for reducing risk to Black service users. My analysis discloses that most AMHP practitioners doubt their capacity to apply social perspectives or exercise independent decisions within the context of multiagency working, organisational factors, resource implications, the dominance of risk, and "blame culture". AMHPs' inability to exercise autonomy and apply social perspectives presents profound implications for Black service users overwhelmingly faced with multiple social issues or disadvantages such as isolation, unemployment, marginalisation, low income, and social exclusion.

This study provides further understanding of how epistemic injustice manifests itself within the mental health service, revealing how Black service users are more susceptible than their white counterparts because of the dual difficulties of experiencing stigma and the negative stereotypes attached to being Black and receiving a mental disorder diagnosis. There is further evidence of AMHPs from Black communities experiencing testimonial injustice from white colleagues ascribing lower credibility to their knowledge and competence due to prejudice associated with their

racial identity. This study suggests numerous ways of enhancing epistemic justice, including the provision of IMHA services during MHA assessments in both the community and hospitals. It highlights that rather than adopting a position of ‘knowing best’, professionals must value and listen to Black service users’ accounts to help reverse the stigma, sense of exclusion, and diminished control and choice that Black people with mental health problems continue to experience.

Acknowledgements

There are several amazing people without whom this thesis would not have been possible. First and foremost, my thanks must go to my two wonderful supervisors Dr Jo Warner and Prof. Michael Calnan, whose wisdom, knowledge, insights, guidance, and patience proved invaluable. I have learnt a lot from you and will be forever indebted to you for your unwavering support and dedication throughout my PhD journey.

I am grateful to all the participants - AMHPs and service users - who so generously sacrificed their time and voluntarily offered me the opportunity to observe and listen to their stories, accounts, and experiences.

Special thanks go to the Associate Director of Social Work, the AMHP Leads, and all the care coordinators and gatekeepers who championed my research. Thank you to the Public Board Advisor expert by experience who advised my research design and facilitated my recruitment of service users. I am also grateful to all the social workers and clinicians who warmly received me in their offices, generously sharing their space, thoughts, and views. I would like to thank Dr Godfred Boahen for his support and for sharing his ethnographic research experience with me.

I am thankful to my former service manager Elizabeth Fajemisin who supported this project during its initial stages by providing flexible working arrangements and encouragement. Thanks also to my friends Tara and Ms Yeboah, and to all my social work colleagues who were there from the beginning, listened, showed interest, and provided emotional support.

My profound and very special thanks go to my revered late father Mr Kofi Ankomako Diamono for being my sounding board and instigating the idea of pursuing a doctorate. It saddens my heart that you are no longer here to witness what you have always wanted me to achieve. I am eternally grateful to you ‘Paapa’.

Finally, I am thankful to my family for accepting and accommodating my academic pursuits and busy lifestyle. Your encouragement and support are a treasure of inestimable value.

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List of Abbreviations

AMHP	Approved Mental Health professionals
ARC	Applied Research Collaboration
ASW	Approved Social Workers
BME	Black and Minority Ethnic
CoP	Code of Practice
CQC	Care Quality Commission
CTOs	Community Treatment Orders
DHSC	Department of Health and Social Care
DoH	Department of Health
IMHA	Independent Mental Health Advocates
MHA	Mental Health Act
MHA Assessment	Mental Health Assessment
NHS	National Health Service
NIHR	National Institute for Health and Care Research
PICUs	Psychiatric Intensive Care Units
WHO	World Health Organisation

Chapter: 1 Introduction

1.1 Introduction

Studies have consistently reported that people from Black and Minority Ethnic (BME) backgrounds are overwhelmingly and disproportionately affected by Mental Health Act (MHA) assessments (Barnett *et al.*, 2019; Keown *et al.*, 2011; CQC, 2018; NHS Digital, 2021). People from these communities are over four times likelier to be detained under the MHA, and more than ten times likelier to be subject to Community Treatment Orders (Mohdin, 2021). BME people are less likely to be provided with psychotherapy, counselling, preventative services, or other alternative care (DHSC, 2018). It has been highlighted that when BME people encounter mental health services they tend to receive unwanted interventions rather than the ones they want or need (Keating and Robertson, 2004; Sashidharan, 2003, Bhui *et al.* 2018); additionally, there are overwhelming concerns about human rights violations in England (CQC, 2018) and across Europe (WHO, 2018).

In this thesis, I use the term 'Black' to refer inclusively to various BME groups. People from BME communities are 40% more likely than the white majority population to encounter mental health services via the criminal justice system (Bradley, 2009; DHSC, 2018). They are disproportionately represented at the top of the spectrum in high-security units (CQC, 2011, Bhui, 2001) and forensic medium mental health services (Thomas *et al.*, 2009). Black peoples' pathways to mental healthcare are well documented as problematic and - once within the mental health system – they experience markedly poorer outcomes (DHSC, 2018; Bhui *et al.* 2018, Williams & Wyatt, 2015, Fernando, 2017).

The disproportionate number of Black people first accessing mental health services through the criminal justice system results partly from professionals perceiving them to be riskier (Nacro, 2007). The overrepresentation of people from BME communities - especially young Black men - in mental health services and all aspects of the criminal justice system indicates an interconnected process of medicalisation and the criminalisation of Black people (Rogers and Pilgrim, 2014). Black peoples' experiences of mental health service interventions have been perceived as forms of social control rather than management for mental illness (Tew, 2005). In other words, the purpose of mental health treatment appears to have shifted from curing to containing Black people (Fernando and Keating, 2009).

Black people are likelier to be associated with risk factors and categorised by the police as mentally unwell, and consequently, prone to detention in a place of safety under Section 136 of the MHA (Rogers and Pilgrim, 2014). In 2021, people from Black communities were twice as likely to receive a Section 136 than their white counterparts (NHS Digital, 2021). Police are often present at MHA assessments and despite best practice stipulating ambulances to be the preferred mode of transport, assessed service users are often conveyed to psychiatric hospitals by police vehicles (Parliament Post, 2022). The presence of police officers can be particularly disturbing and distressing for Black people who may have experienced past negative encounters with the police, resulting in mistrust. This concern may be exacerbated by the multiple high-profile cases of Black people with mental health issues dying in police custody (Adebowale, 2013; DHSC, 2018).

These experiences of social control and coercive interventions often result in Black people with mental health needs steering clear of mental health care. This avoidance often leads to crisis, resulting in police and criminal justice involvement; thereby reinforcing and perpetuating Black people's feelings of being controlled rather than supported (Keating *et al.*, 2002). Given the many negative experiences and outcomes for Black people, it is easy to understand why they regard mental health services with fear, apprehension, and suspicion (Keating and Robinson, 2004).

In the early 1990s, following several homicides committed by individuals with schizophrenia - such as the killing of Jonathan Zito by Christopher Clunis, a Black service user (Ritchie *et al.*, 1994) - and heightened public anxiety ensuing from the resulting media accounts, public safety concerns became more pronounced within mental health policy (Davies, 2012). This particularly intensified the association between young Black men diagnosed with schizophrenia and risk (Warner and Gabe, 2004).

The independent review of the MHA 1983 highlighted that Black people experience ethnic inequalities during psychosis diagnosis and a lower likelihood of being offered psychological therapies (DHSC, 2018). The literature demonstrates that in the UK, Black people are more likely to be diagnosed with schizophrenia than the white majority population (Fernando, 2017), with evidence of institutional racism in mental health services and racial biases during the diagnostic process resulting in higher proportions of Black people receiving a schizophrenia diagnosis (Merino *et al.*, 2018). This is reaffirmed by Fernando's (2017) assertion that racist attitudes are entrenched in the mental health diagnostic process. Schizophrenia is therefore emblematic of the oppression, discrimination, and negative treatment that people from Black communities experience within the mental health system (Thomas, 2012).

The intractable inequalities Black people experience within mental health care, quality of outcome, access to treatment, and restrictions on liberty through involuntary admission are not new (DHSC, 2018). The 2018 independent review of the MHA acknowledged Black peoples' longstanding experiences of discrimination within the mental health system while highlighting that the risk of ethnic inequality within the service experience is undoubtedly intensified by the structural factors that generate racial discrimination, negative stereotyping, and stigmatisation (DHSC, 2018).

The excessive application of the MHA alongside the disparities previously defined that Black people experience suggests a systematic failure to address the needs of these communities (DHSC, 2018). Despite such policy initiatives as the 2005 Delivering Race Equality programme and the implementation of the Equality Act 2010, Black people remain overrepresented within the more restrictive and punitive areas of mental health care, while ethnic inequality in service experience remains unchanged (Rogers and Pilgrim, 2014, Nacro, 2007, and Bhui *et al.*, 2018).

In 2018, the government recognised concerns about the disproportionate number of Black people detained under the MHA (DHSC, 2018), recently announcing plans to reform the MHA in keeping with the recommendations of the 2018 independent review conducted by Simon Wessely (DHSC, 2018). This aims to make the mental health system less discriminatory towards Black people and ensure that compulsory powers are used in the least restrictive ways (Buchanan, 2021).

Despite the literature highlighting the longstanding nature of the problem (Fernando, 2017), little has been studied about the role of one of the key professionals responsible for compulsory admission decision-making: the Approved Mental Health Professional

(AMHP). Under the MHA, AMHPs retain overriding responsibility for deciding whether someone should be detained for compulsory treatment (Brown, 2016). While the institutional elements of this problem have been emphasised within previous research, this PhD will focus on the use of power and discretion in decision-making by AMHPs. This research aims to employ ethnographic methodology to examine detention decisions by AMHPs, drawing upon the applied sociological concept of “risk work” (Brown and Gale, 2018) and the idea of epistemic injustice (Fricker, 2007). More specifically, the objectives of this study are:

- To explore the key influences professionals take into account when forming judgements about compulsory detention;
- To examine how practitioners construct risk when arriving at a decision;
- To explore the views and accounts of BME service users in terms of the care they receive, their experience of detention, and their perspectives about their level of involvement or participation in decisions about their care and treatment.

1.2 Contextualising my interest in the research topic

My interest in researching the role of Approved Mental Health Professionals (AMHPs) in the detention of Black and Minority Ethnic (BME) groups is rooted in my professional practice, academic engagement, and personal experiences. As a social worker and a Black man of Ghanaian heritage residing in the United Kingdom, I have become increasingly aware of the persistent ethnic inequalities embedded within mental health services. During my Master’s degree in social work, I was deeply influenced by literature examining the experiences of Black people within mental health care - particularly the study by Keating and Robertson (2004), Fear, Black People and Mental

Illness: A Vicious Circle? This work highlighted the cyclical nature of fear, mistrust, prejudice, and racialised assumptions in mental health settings.

Motivated by these insights, I focused my Master's dissertation on exploring social workers' perspectives on the detention of BME individuals under the Mental Health Act 1983. The research deepened my understanding of how institutional racism, perceptions of risk, and a lack of cultural competence among professionals collectively contribute to the overrepresentation of BME service users within the mental health system. These findings have continued to shape my academic trajectory. My doctoral research builds upon this foundational understanding and is further informed by the Independent Review of the Mental Health Act 1983, chaired by Professor Sir Simon Wessely, which, as noted above, reaffirmed the existence of systemic racial disparities in mental health care.

1.3 The historical context of mental health legislation and detention

Legislative provisions regulating the civil commitment of people suffering from mental illnesses have been in place since 1714 when Vagrancy legislation was first introduced. This was followed by the Vagrancy Act 1744, allowing the detention of "lunatics and mad persons" (Barber *et al.*, 2012; Bowen, 2007), permitting the confinement of dangerous people to be kept in a safe and secure place during the period of their lunacy (Bartlett, 1998). By the turn of the 18th century, rising sentiment towards the suitability of moral treatment as opposed to traditional containment or confinement approaches became preferable for people suffering from mental disorders (Unsworth, 1987; Phull, 2021). Calls for the increased licensing of 'madhouses' – or mental health institutions - resulted in the Madhouses Regulation

Act 1774 (Barber *et al.*, 2012; Bowen, 2007), providing an arrangement for these establishments to be authorised and inspected by Lunacy commissioners (Bowen, 2007).

In England, concerns over the welfare of people suffering from mental health disorders increased in the wake of reports relating to poor conditions in certain private madhouses. This resulted in the County Asylum Act 1808, providing for the construction of mental hospitals in each English county (Phull, 2021, Bowen, 2007). During that time, the growing industrialisation of society culminated in drastic rises in the numbers of mentally ill people confined to mental health institutions (Unsworth, 1987). Enacted in 1845, the Lunatics Act made the building of an asylum mandatory in each county in England (Bowen, 2007; Hunter and Macalpine, 1974). By the end of the 19th century, these same asylums would become contentious, prompting Parliament to respond to public alarm over poor conditions and unwarranted detention (Noble, 1981).

The history of modern mental health law began with the Lunacy Act 1890, introduced because of growing concerns over the lack of safeguards against the inappropriate detention of people with mental illness (Bowen, 2007). The 1890 Act defined the parameters for admitting people with mental health problems to hospitals, providing a requirement for formal certification through a judicial order, following an application by “relatives or poor law officers” alongside supporting medical evidence (Bowen, 2007, p.13). This Act provided a structure for allowing legal oversight and curtailing medical control (Wilson, 2021), and later, the same requirement was provided for those detained under the Mental Deficiency Act 1913.

The subsequent legislation, the Mental Treatment Act 1930, marked the first considerable shift from the institutional preferences of the late 19th century, permitting anyone who voluntarily wanted to be admitted to a mental hospital to do so without coercion (Barber *et al.*, 2012; Bowen, 2007). This reform also resulted in the renaming of the 'asylum' to the 'mental hospital', and 'lunatic' to 'person of unsound mind'. The 'legalism' associated with the Lunacy Act 1890 was to some degree relaxed by the 1930 legislation, likening the treatment of mental illness to that of somatic illness. This was intended to overcome the challenges associated with the legal certification approach of the Lunacy Act 1890, facilitating early intervention by increasing informal processes that were less stigmatising than formal certification (Wilson, 2021). The Act also restricted the number of institutions while expanding medical services offering out-patient care (Shorter, 2007). Over the 20th century, the deinstitutionalisation of mental health services was rapidly pursued across the UK, expanding mental health care delivery in the community, psychiatric medical advancement including developments in pharmaceutical medication, patient grievance management, and issues relating to costs (Cohen *et al.*, 2014). Introduced in 1959, the Mental Health Act marked further change - removing the requirement for judicial certification before admission and allowing a social worker or close relative to make an application for hospital admission when supported by two medical recommendations (Bowen, 2007). The Act provided for a new Mental Health Review Tribunal intending to deliver judicial oversight by reviewing cases respecting detained patients rather than providing prior authorisation or formal certification (Bowen, 2007).

The Mental Health Act 1959 established the conditions of mental health disorders, risks, and treatments similarly described in the current legislation (Solanki, 2020). It repealed the Lunacy Act 1890, the Mental Treatment Act 1930, and the 1913 to 1938

Mental Deficiency Acts, presenting mental deficiency and mental illness – both new conceptualisations of madness - in one legislative framework for mental disorder (Wilson, 2021). Like the 1930 Act, the MHA 1959 was intended to provide more informal avenues for mental illness treatment and encourage voluntary hospitalisation (Wilson, 2021). The MHA 1959 aimed to end the legal procedures that had for so long characterised mental health legislation, bringing mental health services in line with the emerging welfare state and the National Health Service. These provisions could be viewed as operating in the interest of the state by enhancing the wellbeing and health of its people for social and economic prosperity purposes (Wilson, 2021). The Act also reflected a social expectation that unwell people would take responsibility for their health and would access medical support to resume their social roles upon recovery (Cavadino, 1989). The Mental Health Act 1959 continued the policy shift towards deinstitutionalising people with mental disorders, intending to locate mental health care delivery in the community instead of the institution (Wilson, 2021).

The MHA 1959 retained the harm criteria defined by the Lunacy Act 1890; however, risk assessments now permitted two medical certificates without the need for judicial involvement. The Act also ended the participation of the board of control and the previous means for providing external supervision or the oversight of medical discretion. The 1959 Act effectively entrusted medical professionals with unfettered powers, and unsurprisingly, attracted considerable criticism, particularly from the anti-psychiatry movement of the time (Wilson, 2021).

The broad range of discretionary powers conferred by the MHA 1959 on psychiatrists failed to safeguard the rights of individuals with mental illness. This paved the way for further reform, leading to the MHA 1983. This Act emphasised safeguarding the right of patients to apply for review of compulsory admission, as well as a right to be offered treatment in the least restrictive environment (Phull, 2021). While the 1959 Act favoured ‘informality’ over ‘legalism’, the MHA 1983 swung the pendulum back in favour of greater regulation and control over the hospitalisation and treatment of persons suffering from mental illness (Bowen, 2007). The 1983 Act facilitated greater legal control of the admission and treatment of patients, introducing threshold criteria for extended powers of compulsion, the introduction of the requirement to treat persons with ‘mental impairment’ and ‘psychopathic disorder’, and the strengthening of powers allocated to nearest relatives (Bowen, 2007). The harm criteria defined in the MHA 1959, concerning risk to self and others remained the same, but the duration of admission for treatment and care was reduced from one year to six months (Wilson, 2021). While the MHA 1983 provided an emphasised procedural safeguard for patients’ rights, the discretionary medical authority was left unchanged. Unlike the MHA 1959 that omitted agreement to treatment, consent dominated the 1983 Act (Hilton, 2007). This created an Approved Social Worker (ASW) role for performing specific legal duties including completing assessments, applying for the compulsory detention of people with mental illness, and “recommending and applying for guardianship” (Campbell *et al.*, 2001, p. 156). ASWs became central figures in protecting service users’ rights, particularly because patients were not permitted immediate access to judicial review during the detention process (Gostin, 1975).

Significant events in the 1990s moved public attitudes from sympathy for the health and welfare of people with mental disorders to growing fear and anxiety over their potential danger (Killapsy, 2006). Concerns for public safety emerged after certain high-profile homicides committed by mentally ill patients in the community, including the 1992 killing of Jonathan Zito by Christopher Clunis, and the 1996 murders of Lin and Megan Russell by Michael Stone (Barber *et al.*, 2012).

The MHA 1983 was amended in 2007 to emphasise risk management, public protection, and medication compliance, introducing Community Treatment Orders (CTOs) and replacing ASWs with Approved Mental Health Professionals (AMHP). The role of AMHP was essentially the same as performed by the ASW, but the Act expanded the range of professional groups - social workers, clinical psychologists, mental health/disability nurses, and occupational therapists - who could exercise powers of compulsion and make detention decisions (Stone, 2018, Barber *et al.*, 2012).

1.4 The current context

In England, the Mental Health Act 1983 is the statutory instrument for managing the mental health needs of people who require involuntary hospital treatment. Central to this is the role of the AMHP who holds a statutory mandate to detain people for their care and treatment (Brown, 2016). Even though the 2007 amendment broadened the range of professionals afforded these powers, it remains primarily a social work activity, with social workers comprising ninety-five per cent of AMHPs (Carson, 2018). Their role includes involvement in multi-agency work and conducting MHA assessments to establish risk thresholds for detention (Knott and Bannigan, 2013). They must consider the least restrictive options or alternatives to detention to ensure that they use their compulsory powers lawfully, balancing the independence of the individual while safeguarding them, their family, and the wider public (DoH, 2015; Brown, 2016).

As part of their role, AMHPs receive specific training in the application and understanding of the Mental Health Act. They must also draw on their knowledge and skills as well as their professional values to inform the assessment, consider family and relationship dynamics, and social circumstances or factors such as employment, housing, deprivation, poverty, and the impact of life events. AMHPs also receive cultural competence training and therefore, will be aware of the impact during a mental health assessment of race and culture within a mental health context (Hatfield, 2007). Although detention decisions take place in a multi-disciplinary framework ostensibly dominated by the bio-medical model embodied by psychiatry (Bonnet and Moran, 2020), my study focuses on the AMHP precisely because social work is supposed to steer away from this model (Hall, 2017) towards holistic social perspectives or processes.

As per Section 13 of the MHA, AMHPs must exercise independent decision-making (DoH, 2015) as to whether to apply for detention, based upon several factors including medical and social evidence, outside the command of their employers or other professionals from the multi-agency team, such as doctors (Brown, 2016). Notionally, AMHPs should be “independent arbiters”, standing up for service user rights, and maintaining an independent perspective while counterbalancing and challenging the medical model (Knott and Bannigan, 2013; Hall, 2017). However, there is little evidence as to how they discharge these vital functions. Most existing research into the rising rates of detention under the MHA has tended to focus on psychiatrists’ perspectives (Bonnet and Moran, 2020; Keown *et al.*, 2011; Campbell, 2010; Fistein *et al.*, 2016;). Within the existing literature, there are limited direct observational studies into the actual practice of assessing people for compulsory admission for mental health treatment.

Given their unique role and powers, we require a better understanding of how AMHPs make detention decisions, particularly concerning people from Black backgrounds who are overrepresented within the mental health system and experience inequalities when accessing mental health treatment (NHS Digital, 2018; Bhui *et al.*, 2018).

1.5 Structure of the thesis

This thesis consists of seven main chapters. This first chapter provides an introduction to the historical context of detention under the MHA and the background for the research. It also outlines the aims and purposes of the study. Chapter 2 contextualises the thesis by reviewing the relevant literature. This analysis is broken into five main themes: the assessment and management of risk; accountability; social perspectives and contexts; alternatives to compulsory hospital admission; and Black people and compulsory detention under the MHA. It also outlines the research questions generated from the literature review. Chapter 3 presents the theoretical framework for exploring the work of the AMHP. I integrate risk work theory and the idea of epistemic injustice into a single framework to inform this research. The following chapter 4 outlines my methodological approach to answering my research questions; outlining my methods of data collection and analysis, ethical consideration, reflexivity, and researcher positionality. The research findings and analysis are thematically presented in chapters 5 and 6. In Chapter 7, I discuss the findings in the context of the existing literature relevant to this study and assess the value of the theoretical framework in light of this; while concluding with implications for policy and practice, the strengths and limitations of the methodology, as well as the considerations for future research.

Chapter: 2 Literature Review

2.1 Introduction

This chapter presents a critical appraisal of the body of literature pertaining to this current study. It begins by outlining the search strategies used to identify the relevant literature, followed by a description of the approach employed to critically evaluate the selected studies. The chapter then provides an overview of the wider context of risk and mental health and considers its relevance within empirical research. Subsequently, it reviews empirical studies related to the work of the AMHP and how they make decisions about detention during MHA assessments, identifying gaps in the knowledge while assessing their contribution to answering this study's research questions. While there is a vast amount of literature that is potentially relevant to this research, I will be focusing on those studies and analyses that explicitly address AMHP decision-making. These studies have been sourced from various disciplines and subject areas, including social work, sociology, and mental health/psychiatry. For critical analysis purposes, I have categorised the literature under five main themes: the assessment and management of risk; accountability; social perspectives and contexts; alternatives to compulsory hospital admission; and Black people and compulsory detention under the MHA. I have given particular consideration to the detention decisions of AMHPs and the implications for Black service users who are reported in the literature to be disproportionately affected by MHA assessments. This chapter concludes with a summary of the key findings/issues and identifies the gaps in the existing literature which my research seeks to address. Importantly, I will describe the theoretical framework reinforcing part of the existing literature in chapter 3.

2.2 Strategy for literature search and the critical review process

To identify empirical studies related to my research topic - the role of the AMHP in relation to the detention of Black people under the MHA - I conducted a series of electronic searches using databases such as SCOPUS, Social Care Online (SCIE), and the Applied Social Sciences Index and Abstracts (ASSIA). I also employed reference chaining to locate additional studies. In addition, I searched grey literature sources, including EThOS, the Department of Health and Social Care, the British Association of Social Workers, Community Care, and Google Scholar.

In the initial phase of the literature search, I used a broad range of search terms, but as the process progressed, I refined and narrowed these to focus on key terms, including: Approved Mental Health Professionals (AMHPs), Mental Health Act 1983, Black and Minority Ethnic groups (BME/BAME), African Caribbean, social work, AMHP decision-making, MHA assessment, risk assessment, detention, compulsory admission, disproportionality, ethnic disparities, mental illness, and mental disorder.

The inclusion criteria for this literature review were as follows: primary research focusing on the role of Approved Mental Health Professionals (AMHPs); studies examining risk assessments conducted under the Mental Health Act; literature exploring the experiences of Black individuals with mental health needs; and research addressing ethnic disparities or disproportionality within mental health services. Only studies published in English from 1983 onwards were considered. The year 1983 was selected as the starting point, as it marks the introduction of the role of the Approved Social Worker (ASW) under the Mental Health Act, a position subsequently replaced by the AMHP role in 2007. A total of 77 studies met the inclusion criteria and were incorporated into the review.

Having selected literature relevant to my research based on predefined inclusion criteria, I conducted a critical review of the chosen studies. This process went beyond simply summarising existing work, involving a thorough evaluation of their quality, relevance, and contribution to my research question (Ridley, 2012). I followed the approach outlined by Shah et al. (2018) which involved multiple iterative readings of each study, during which I consistently adopted an analytical and evaluative stance. In the initial readings, I extensively annotated the texts, making detailed notes that captured not only the substantive content of the studies but also their methodological choices. A central component of this stage was the critical appraisal of each study's strengths and limitations, while paying particular attention to how each study contributed to the broader discourse surrounding my research topic.

After completing the in-depth reading phase, I proceeded to summarise the recurring issues, capturing core arguments, and key findings of each study. I identified common themes and points of contention across the literature. These insights were then organised into thematic categories, which enabled a structured and coherent critical discussion in the subsequent stages of my review. This thematic organisation served not only to highlight areas of consensus and divergence within the literature, but also to identify gaps and opportunities for future research, thereby sharpening the focus and rationale for my own study.

2.3 Risk and Mental Healthcare

There has been a continuous debate on whether contemporary society is a "risk society" (Beck, 1992), becoming overly risk-averse (Davies, 2012) and less tolerant of positive risk-taking (Harrison and McDonald, 2008). Beck (1992) contends that contemporary society is characterised by an increased awareness of risk, alongside a loss of faith in technology and professional expertise (Horlick-Jones, 2005). From this sociological standpoint, risk is constructed by social groups who decide what events are deemed to be risks and determine their response (Lupton, 1999, Horlick-Jones, 2005). This literature highlights that those who undertake risk work construct those individuals associated with risks or threats to others as requiring management (Stanley, 2018; Horlick-Jones, 2005). The concept of risk is utilised to describe and explain the nature, management, and experience of risk in daily professional practice (Turnbull *et al.*, 2017).

Aven and Renn (2010) observe that risk is a complex and multifaceted concept, and although there is no conclusive or agreed definition of risk, it is interlinked with the concept of uncertainty. Lupton (1999, p.9) states that "risk and uncertainty tend to be treated as conceptually the same things"; while Aven and Renn (2010) define risk as "an event where the outcome is uncertainty" (2010 p.3). Uncertainty is associated with "not knowing for sure what will happen" (Macdonald and Macdonald, 1999, p.17; Grote, 2015), and circumstances where it is impossible to quantify or meaningfully calculate probabilities (Pettersen, 2016). The concept of risk and the conditions of uncertainty are particularly important to mental health assessment and treatment (Brown *et al.*, 2009), with the decision-making processes of mental health social workers largely shaped by risk (Stanley, 2018).

Mental health policies driven by risk (Pilgrim, 2007) can affect "users' trust in services" and generate "dynamics within organisations" which may have a pernicious effect on trust and working alliances (Brown *et al.*, 2009). Risk reduction or minimisation may create tension for professionals in terms of their commitment to promoting a client's autonomy and choice (Hall *et al.*, 2012), and establishing trust (Brown and Calnan, 2013). Power (2004) notes that the increased emphasis on risk within professional work and organisational contexts involves a shifting of accountability downwards to frontline professionals. Consequently, professionals have become more defensive and risk-averse for fear of being blamed or held accountable should poor outcomes occur (Davies, 2012). There has been a notable shift in the way social workers engaging in risk work are held accountable for the adverse outcomes or failings of social care interventions, placing them in a vulnerable position, and consequently, succumbing to media narratives and public pressure by reorienting their work towards defensive practices (Warner, 2015; 2006). Spendlove's (2018) study shows that this preoccupation with risk in everyday work – and the requirement of evidence that risk reduction is occurring, through extensive paperwork - can be counterproductive when caring for patients. Evidence-driven practice, a focus on objectivity, and the requirement to appraise risk decisions have led to professionals adapting or reconfiguring their working practices - instead of questioning or resisting the evidence - due to feelings of fear and anxiety about "potential blame" (Brown and Gale; 2018, p.7; Spendlove, 2018). Accordingly, practitioners feel more comfortable framing their risk decisions in objective ways for fear of potential adverse outcomes occurring (Stanley, 2018).

Risk work is an aspect of emotional work involving the management of professional anxiety (Brown and Calnan, 2013; Stanley, 2018). The risk narrative presented within mental healthcare has amplified concerns and manufactured professional anxiety; this fear of accountability relates to the risks associated with mental illness and the assessment and handling of such risks within the context of daily practices (Gale *et al.*, 2016; Beddoe, 2010). The heightened anxiety of other professionals can significantly impact workers' decisions as to how they conceive of the risk represented by a particular social group (Stanley, 2018). This highlights the issue of ethnicity and its implication to AMHP decision-making concerning the mental health needs of people from Black communities, with the literature establishing that Black service users - particularly young Black males - are perceived by professionals as more "risky" and "dangerous" (Nacro, 2007). Frost and Hoggett (2008) observed that rising rates of detention and the strikingly disproportionate representation of young Black males in the more punitive and coercive areas of mental health management demonstrate the profoundly negative experience and suffering caused by the social construction of the "black other".

There has been a shift in the way risk is conceptualised in mental health services, with a growing emphasis on the risks presented to others/the public by mental health service users, in comparison to the profound risks they experience and encounter themselves (Warner *et al.*, 2017). Since the implementation of community care in the 1990s, there has been an overwhelming emphasis on a perceived escalation of risk that individuals with mental health issues pose to others in the community. The professional's risk assessment is now perceived as the process required to protect and ensure public safety, alongside guaranteeing the welfare of people who are mentally unwell and "dangerous" (Grounds, 1995). This focus on the risk of violence to others by people with mental health problems - and concerns for public safety - was accentuated by the enquiries into the homicides committed by individuals suffering from schizophrenia in the early 1990s, including the killing of Jonathan Zito by Christopher Clunis, a Black service user (Ritchie *et al.*, 1994), and the resultant influence of powerful media campaigns and the heightening of public anxiety (Davies, 2012). As a direct consequence, various governments have pursued risk or public safety agendas (Fennel, 2007), with high-risk categorisation closely linked to people with mental health difficulties deemed to pose a risk to others/the public rather than to themselves (Warner, 2008).

Decisions require legitimisation to justify detention (Stanley, 2018). This means that by employing an account of potential risk, AMHPs can validate their decisions; however, it should be recognised that those who are subject to these assessments are required to live with the consequences (Stanley, 2013). Stanley (2018) argues that social workers should apply reflexivity and critical engagement to risk work, challenging risk categorisation by other professionals according to their own assessments and considering a person's social circumstances. This can prove demanding, but it is arguably oppressive and unethical to classify someone's behaviour in escalating risk terms according to the fear and anxiety of others (Stanley, 2018).

2.4 Assessment and management of risk in AMHP decisions relating to detention

The literature indicates that AMHP detention decisions heavily rely on risk assessment and management, reflecting the risk criteria outlined in the MHA 1983 and the 2007 amendment for considering the 'risk' both to patient health or safety and the protection of others (Brown, 2016; Simpson, 2020). Decision-making in mental health practice has always involved an aspect of risk assessment (Thomas-Glover, 2011). One of the central focuses of the amended 2007 MHA is the risk presented by the service user to others – driven in part by political pressure and heightened public anxiety concerning the containment and management of people with mental health problems (Glover-Thomas, 2011). Fennel (2007) contends that various governments have followed a risk or public safety agenda, as a direct consequence of concern following homicides by persons suffering from mental disorders.

The MHA reinforces this dependence on risk discourse within practical decision-making by mental health professionals and the increased application of standardised risk assessment tools (Glover-Thomas, 2011). In this respect, the AMHP's decision-making process can be viewed as 'risk work'; a balancing act between positive risk-taking and risk reduction through probabilistic approaches (Davis, 1996). However, as Coffey *et al.* (2017) observe, the requirement for professionals to assess risk may not achieve the policy objectives of minimising risk and reducing bad outcomes due to poor predictive ability and a fear of undesirable results generating risk-averse practices. It is also notable that the lack of clarity about risk thresholds and an inconsistent understanding of risk produce variable outcomes under the MHA assessment (O'Hare *et al.*, 2013; Sheppard, 1990; Glover-Thomas (2011). The subjective nature of ASW/AMHP decisions and the construction of risk is highlighted in the literature (Sheppard, 1990), with evidence of varying decision-making amongst practitioners (Peay, 2003; Stone, 2019). Sheppard (1990) undertook semi-structured interviews with nine ASWs, focusing on risk assessments by practitioners, and finding that risk criteria played a significant role in detention decisions. He emphasised the subjective and interpretive nature of these, highlighting that most ASWs focused on the patient's mental illness merged with risk.

Stone (2019) identified that decision-making over whether to detain a person appeared inconsistent and subjective, with various professionals within mental health teams constructing risk factors in varying ways, echoing the findings in Sheppard's (1990) research. Unfortunately, the question as to how AMHPs construct cases or risk when arriving at decisions is beyond the remit of these studies and remains unanswered. Of further relevance to this thesis is Stone's proposal for an ongoing review relating to AMHP decision-making from the referral discussion to the detention decision, as the majority of AMHP practice occurs away from public scrutiny where independent appraisal is impossible. Using vignettes and semi-structured interviews to gather data from 20 AMHPs (ten social workers and ten nurses), Stone (2019) discovered that a deficiency of information about the person being assessed lowered the risk threshold. The objective of this study was to understand the management and assessment of risk - rather than the risk emerging from the data - and its findings may have been impacted by the research sample, considering that despite the role being extended to non-social work professionals - mental health/learning difficulties nurses, occupational therapists, and psychologists - the vast majority of AMHPs remain social workers (Carson, 2018),

Glover-Thomas's (2011) study examining risk perception and determination following the 1983 MHA amendment identified the importance of knowing the person when determining whether compulsory detention was necessary. Quirk *et al.* (2003) confirm this, identifying that ASWs raised their risk tolerance when the assessed person was already known to the service. While some of the participants in Glover-Thomas's (2011) study highlighted its importance during the decision-making process, others perceived that clinical history and previous encounters with psychiatric services should not prejudice an assessment of someone’s current mental health status. It is acknowledged that the prejudicial influence of clinical history on decision-making implies that the management and assessment of risk is not an entirely “value-neutral, fact-finding exercise” (Glover-Thomas, 2011, p. 298). These seemingly conflicting positions regarding the influence of a service user’s clinical history reflect the subjective and interpretive nature of the AMHP detention decisions evidenced (Stone, 2019; Peay, 2003; Sheppard, 1990). Intending to address the subjectivity of these decisions, Glover-Thomas sought to explore how risk assessment might be standardised by decision tools, however, she identified that professionals desired to use their discretion when approaching risk. That decision tools have not been commonly adopted by AMHPs during MHA assessments confirms the subjectivity of decisions regarding risks and detention (Simpson, 2020).

Buckland’s (2016) study identified medical and risk discourses deployed by professionals to justify admission and detention. She focused on the decision-making of AMHPs, finding her participants localising mental illness treatment to hospitals, with limited focus on alternatives to involuntary admission. Buckland conducted interviews with ten AMHPs each detailing a recent memorable assessment according to Foucauldian discourse analysis – a methodology reliant on a specific understanding of the function of power, discourse, and language, but biased towards power asymmetry. The study adopted a social constructivist position, examining how detention under the MHA is “discursively constructed, mapped, negotiated and understood” by participants while drawing on a theoretical framework concentrated on power, language, and discourse to advance understanding of AMHP practice. Buckland’s study indicated that professionals utilised personal and professional subject positions to grasp the meaning of mental illness, with the suitability of available treatment – categorised by participants as the “right thing to do” - identified as the most significant component of detention decisions. While the semi-structured interviews and discourse analytic methodology deployed by Buckland furthered understanding of how AMHPs interpret and use compulsory detention powers under the MHA, it mirrored most existing studies relating to the role by lacking direct observational data that might produce insight into their actual practice, as opposed to normative perspectives and their reported behaviour. This proposed study aims to rectify this.

Research about AMHP decision-making has indicated a lack of clear boundaries between voluntary and compulsory admissions to psychiatric hospitals (Kjellin *et al.*, 2006); and gaps between practitioner and patient perceptions of risk, treatment, and care, and how this is experienced by patients (Kjellin *et al.*, 2006). Whereas the risks presented by a person assessed under the MHA may often require an involuntary hospital admission (Buckland; 2016), it is argued that risk is not merely that which an individual might do but the interpretation and meaning attributed to a behaviour or its possibilities (Warner and Gabe, 2008). Therefore, while the MHA assessment is centred on risk to self and others, it is worth noting that the construct of risk is debatable and socially constructed (Szumuler and Rose, 2013), requiring practitioners to consider other complicating factors and much broader issues, including iatrogenic harm resulting from involuntary admission, the need for positive risk-taking, and negotiating the balance between care and control (Boardman and Roberts, 2014).

Simpson (2020) explored the factors influencing AMHP decisions about compulsory hospital admission under the MHA 1983, thematically analysing 25 papers and identifying risk, accountability, and morality as key and dominant themes. Simpson described morality as the “use of the self to understand another”, and the fusion of personal and professional values to understand patients' presenting issues. The study highlighted the prominence of risk, reflecting the basis for medical recommendations under the MHA in sections 2 and 3, however, risk-based decisions were found to be subjective and infused with morality rather than technical judgements. The study highlighted how morality manifested through how practitioners combined both personal and professional dimensions, using themselves to make sense of service users' situations in detention decisions. Considering the influence of morality on AMHPs, Simpson questioned whether services should offer support when dealing with moral engagement in their everyday practice.

Coffey *et al.* (2017) undertook a study to explore the contents of care plans and the multiple perspectives of service users, family members, and workers concerning risk assessment and management, using qualitative interviews with service users, family members, and workers across four English and two Welsh National Health Service sites. It was identified that participants held differing perspectives regarding risk. Service users recognised the benefit of talking about risk but were suspicious of its importance being used by workers to undermine their independence. It was notable that service users and their families did not see themselves as active mental healthcare consumers but merely recipients of professionals' instructions, uninvolved in the decision-making about their care and treatment. On the other hand, professionals identified risk as emanating from the individual rather than social factors. They were more concerned with following assessment procedures and proved intolerant to positive risk-taking. Thus, workers avoided involving service users in discussions relating to risk, inclining towards aversion and erring on the side of caution. Coffey *et al.* (2017) observed that good relationships with professionals were central to service users and family members, although claims by professionals of collaborative work with service users in the care planning process did not stretch to the assessment and management of risk. This constitutes an element of epistemic injustice, disadvantaging service users by denying them the opportunity to develop understanding and further knowledge of their condition (Coffey *et al.*, 2017). This current thesis will attempt to comprehend such matters by exploring whether a service user's knowledge, experience, and circumstances are considered by practitioners when forming their judgements about detention.

The role of individual differences concerning how professionals assess risk (Bartlett, 2010), intuition according to professional experience (Glover-Thomas, 2011), and "practice wisdom" (Sheppard, 1995; Vicary, 2017) are all stressed in the literature as factors influencing detention decisions. Sheppard referred to professionals drawing on their practice wisdom - developed through life or practice involvement - to form their judgements. Glover-Thomas (2011) highlighted how gut feeling consistent with professional experience in the decision-making context directed risk assessment outcomes. She discovered that professionals filtered risk factors through "personal intuition" to arrive at a decision. Glover-Thomas's (2011) study sought to investigate whether the amended MHA strengthened risk as a dominant focus during judgements while considering how professionals might deploy risk to facilitate or help in their everyday practice. The MHA fails to define risk or the germane factors that characterise it. While the code of practice provides some guidance, what counts as a risk to self or others is left to the discretion of decision-makers. The lack of clear definitional parameters around risk poses further questions as to the extent of its perception and how to establish it (Glover-Thomas, 2011). In practice, the risk criteria for AMHPs implied a need to strive to create the right balance between a service user's autonomy and protecting the public from possible harm. The objective of the MHA is to ensure decisions are made to reduce undesirable outcomes resulting from mental illness by increasing safety (DoH, 2015). Thus, risk provides the lens to realise this balance. However, this centres on subjective interpretation, with this type of decision-making being predisposed to errors and inconsistencies (Glover-Thomas, 2011).

A patient must be diagnosed as having a mental disorder as defined in the MHA, under Section 1, for the AMHP to use their detention powers. The criteria for arriving at a decision is unclear, and for this reason, decision-makers use their discretion to interpret factors relevant to detention decisions. Glover-Thomas (2011) found that a person's risk to self or others was used as a principal reason for all such decisions, yet despite its significance in the decision-making process, the respondents in her study unanimously conceded that there was no clear definition of risk or measures for its determination. It highlighted that decision-makers constructed working definitions that often seemed obscure and incomprehensible. Many decision-makers could not define risk, stating it to be self-evident – a "risk is risk paradox" - without being able to clearly explain its constituting factors. This was supported by O'Hare (2013) who observed that practitioners had an inconsistent understanding of risk. The lack of clarity and negotiable threshold regarding MHA implementation may not only affect service users' rights but also erode public trust in the entire system (Glover-Thomas, 2011).

As emphasised in this review, the policy objective or purpose of the MHA is to ensure decisions are made intending to reduce undesirable outcomes resulting from mental illness by increasing safety and welfare. In theory, risk offers a useful tool by which practitioners may attain this balance, deploying detention powers under mental health legislation where an individual presents a risk to themselves and others. However, this review establishes that this has proven a subjective exercise and is often erroneous and inconsistent (Glover-Thomas, 2011). Considering the prevalence of risk and the subjective process involved when applying compulsory powers, this theme reinforces the value of observing the actual practice of AMHPs and how they construct risk during MHA assessments. This research seeks to address this void.

Risk is intricately linked with accountability, where frontline practitioners (AMHPs) are held responsible for bad outcomes resulting from their judgements. For example, if a practitioner's decision results in harm - or even the death - of a service user, they may be held accountable. It is highlighted that the mounting emphasis on risk across professional work and organisational contexts involves a shift in accountability downwards to frontline staff (Brown and Gale, 2018). Consequently, these professionals have become more defensive and risk-averse for fear of being blamed or held accountable should bad outcomes occur (Davies, 2012).

2.5 Accountability

The literature highlights that AMHPs are wary of adverse consequences, given their level of discretion and independence regarding detention decisions enshrined in the MHA (DoH, 2015). AMHPs are required to have the skills and knowledge during an MHA assessment to exercise independent decisions and be “personally accountable” for their practice (Golightley 2014, p. 71). The literature reveals that practitioners’ anxiety about accountability for negative outcomes occurring, public scrutiny, and “blame culture” affects their detention decisions (Quirk *et al.* 2003). Accountability in this sense refers to being culpable or responsible for adverse outcomes. As Douglas (1990, p. 6) succinctly states, this is the “forensic function” of risk; the identification of who is to blame when bad things happen.

The decision-making process of an AMHP may be affected by the stressful nature of their role and anxiety about professional accountability for potentially undesirable outcomes following their judgements (Simpson, 2020; Peay, 2003). Gregor (2010) identified that practitioners experienced emotional distress from their legal obligation to make detention decisions. This can be exacerbated by the challenges associated with multiagency working (Davidson and Campbell, 2010; Furminger and Webber, 2009). Partnership working among professionals from different disciplines tends to undermine the decision-making process of an AMHP thereby worsening the plight of service users and their carers when considering compulsory detention (Bowers *et al.*, 2003; Furminger and Webber, 2009; Davidson and Campbell, 2010). Similarly, Kinney (2009) writes about his preference for a holistic assessment, including risk factors and social circumstances, being overturned by other professionals. His account highlights how power dynamics and organisational values - both implicitly linked to accountability - influence decisions about detention (Simpson, 2020). This is reaffirmed in Campbell's (2010) study, indicating that organisational factors and management pressure on practitioners may potentially impact assessment, guiding detention decisions through their perception of accountability.

Kinney (2009) explored the ethical conundrums faced by AMHPs during the detention process, arguing that following a doctor's medical recommendations for compulsory hospital admission, the promotion of a patient's independence or choice will compete with concerns over professional responsibility for risk-taking. This fear of consequences leads to risk-averse options being considered (O'Hare *et al.*, 2013; Fistein *et al.*, 2016). This was echoed in Buckland's study (2016), highlighting that her participants associated defensive practices in response to a fear of personal accountability with public discourses on risk. Similarly, Coffey *et al.* (2017) discovered that professionals encouraged risk-averse options fearing ramifications should adverse outcomes occur. This is closely aligned with uncertainty about risk being identified as a contributing factor to detention decisions in the literature. Peay (2003) identified that this insecurity created risk-averse decision-making and a lack of positive risk-taking. This was supported by Buckland (2016) and Skinner (2006), who emphasised the prevalence of uncertainty in the assessment process and its direct association with accountability and defensive practice. Peay (2003) found that detention decisions were driven by a fear of adverse outcomes arising from deciding not to detain, while Quirk *et al.* (2003) determined that support from other professionals minimised the likelihood of compulsory hospital admission.

Fistein *et al*.'s (2016) study into decisions relating to involuntary admission revealed that participants felt compelled to detain patients out of fear of liability for any future harm that individuals might otherwise cause. Skinner (2006) supported this, identifying that professional accountability played a significant role in detention decisions. Fistein *et al.* (2016) used observation and in-depth interviews with medical practitioners and AMHPs to explore how detention decisions were made in practice. The study sought to understand the principles and grounds for detention decisions; it also aimed to examine how and why these decisions may conflict with a legal framework defining the conditions and circumstances under which lawful detention may occur. The study identified six themes that influenced decision-making: diagnosis; the availability of alternatives to detention; the likelihood of a response to treatment; the risk assessment; the service user's capacity to make treatment decisions; and the degree of complexity embedded in the decision-making. Some of these findings demonstrating the complexities of decision-making and concerns about accountability are consistent with wider research. However, there were a limited number of AMHPs involved in the study – while five AMHPs participated in its observational element, only one AMHP was engaged in the interview section. While the writers highlighted the strength of the observational portion of the study, it only included discussions between medical practitioners and AMHPs following MHA assessments for deciding whether an assessed person met the criteria for compulsory detention. Consequently, the study did not involve observation of actual assessments or interactions between practitioners and service users, which is of particular interest to this current study.

Skinner (2006) sought to understand the experiences of practitioners conducting mental health assessments, identifying that professional accountability and liability contributed significantly to detention decisions. Skinner's study involved semi-structured interviews with mental health professionals intending to explore their experiences of the mental health process. Her participants comprised of seven ASWs, two senior nurse practitioners, one psychiatrist, and a specialist registrar. The study's findings suggested that the combination of accountability, performing competing functions, the conflicting values emanating from working with others, and practising in a highly charged environment could prove highly stressful, burdensome, and "anxiety-provoking" for practitioners involved in the MHA assessment. While this study illustrated how practitioners were impacted, its purpose was not to explore how detention decisions were made. Recognising this knowledge gap, Skinner proposed further observational studies relating to decision-making under the MHA.

2.6 Social perspectives and contexts

The third distinct theme emerging from the literature concerned social perspectives and contexts. The concept of a 'social perspective' is subject to a wide range of interpretations, with no straightforward definition of the term included in the MHA Code of Practice (DoH, 2015). Tew (2005) recognises this ambiguity but attempts to identify several core elements, including an emphasis on lived experiences and situated knowledge explored through an exchange of information and dialogue; a departure from pathologising people with mental health needs; and taking a holistic approach that considers people in their environment, such as family situations and socio-economic positions. According to Tew, the 'social perspective' should reflect the principles of anti-oppressive and empowering practices, highlighting an awareness of social factors that could disadvantage people (Tew, 2005). Consequently, professionals should be committed to taking full account of people's voices, social circumstances, and testimony about their mental health problems, in contrast with a medical model focused on symptoms (Tew, 2005). This is supported by the guiding principle of empowerment and involvement - referenced under s118 in the Code of Practice - highlighting that service users should be fully involved in decisions about their care and treatment while considering the views of families and carers when making judgements (DoH, 2015).

The vast majority of AMHPs are social workers (Carson, 2018; Brown, 2016) entrusted with advocating for vulnerable people, requiring a commitment to listen and take full account of what they say, championing social justice, and promoting anti-discriminatory practices (Tew, 2005). Crucially, the Department of Health (DoH, 2015: 122) Code of Practice for the Mental Health Act 1983, updated in 2015, states that:

> The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principle.

AMHP practice is reinforced by section 118 of the MHA and the Code of Practice (DoH, 2015), stipulating social perspective as an important feature of AMHP work. Social perspective is also represented in mental health policy (DoH, 2011) and several social work position statements (Allen, 2014; Allen *et al.*, 2016). Detention decisions occur in a multi-disciplinary context ostensibly dominated by the medical model embodied by psychiatry (Hall, 2017). The social perspective feature of the AMHP role remains a significant counterbalance to the overriding medical discourse found across mental health services (Knott and Bannigan, 2013; Coffey and Hannigan 2013). Emphasising the social perspectives of AMHP work illustrates the importance of challenging medical hegemony and its associated power asymmetry, while working to promote positive risk-taking, user participation, and rights-based interventions to resolve the social determinants of mental health problems (Karban *et al.*, 2020). However, despite the potential for positive engagement and empowerment, the state response to risk management (Felton *et al.*, 2017) and conflicting policy objectives bode poorly for the likelihood of practitioners readily adopting positive risk-taking (Basset and Stickley, 2010). In this context, positive risk-taking involves embracing a greater degree of risk and uncertainty compared to conventional, risk-averse approaches that prioritise a 'safety-first' approach. It centres on the needs of the service user, aiming to empower decision-making, support autonomy, and promote social inclusion (Titterton, 2011).

The literature highlights that despite the centrality of social perspectives in AMHP practice, there remain challenges to its implementation in light of structures within organisations and the perception of risk, which is invariably understood to be embedded in AMHP decision-making (Campbell, 2010; Karban *et al.*, 2020). In their recent qualitative study following the perspectives of AMHPs as to how recovery and social perspectives are applied when conducting MHA assessments, Karban *et al.*

(2020) identified that their participants regarded these concepts to be essential elements of their practice. However, AMHPs also acknowledged that when it came to assessment and risk management, this consideration could become secondary. Examining how AMHPs account for recovery and social perspectives when undertaking MHA assessments, this study used semi-structured interviews with twelve AMHPs who were all social workers. Its key findings suggested that its participants considered social perspectives in terms of the “social side of things”, trauma and abuse, and the iatrogenic harm resulting from mental health service involvement. The study identified AMHPs’ nuanced understandings of social perspectives and how they perceived these ideals as essential to their role; acknowledging its complexities and the differing ways in which they attempted to incorporate these concepts into their decision-making. While the study illuminates AMHPs’ understandings of social perspectives and how they attempt to translate this into their everyday practice, it is worth noting that the authors of this study were involved in the delivery of the AMHP training course and had previously taught some of the research participants prior to qualification, and therefore, the researchers' pre-existing relationships with the interviewees may have influenced the outcome of the interviews. Additionally, the study did not consider the perspectives or experiences of service users who had been assessed and/or detained under the MHA, as recommended in the recent independent review of the MHA (DHSC, 2018), and which the current study aims to address.

Hatfield (2008) undertook a study exploring the social circumstances of people assessed by ASWs, determining key features including isolation, lack of material resources, and lifestyle problems - such as substance misuse - that affected individuals’ mental health conditions. Hatfield identified evidence of a close association between social issues and mental health crises, concentrating on the challenging nature of MHA assessments completed by decision-makers. Notwithstanding the immensity of this task, Hatfield rationalised that social workers were equipped with specific abilities for identifying structural issues and social factors contributing to serious mental health issues. She also added that the skillsets of mental health social workers and their knowledge regarding community services placed them in a good position to coordinate appropriate responses and organise alternative services mitigating the need for hospitalisation. However, there is an ongoing debate in the literature about how AMHPs incorporate social perspectives in their detention decisions within the context of organisational policy and resource implication that tends to hinder working alliances or empower engagement with service users (Campbell, 2010; Davidson and Campbell, 2007). The literature demonstrates that in light of dominant medical discourses about mental disorders and the preoccupation with risk - which the MHA implicitly reinforces - AMHPs are faced with the challenge of applying social perspectives during assessments and making decisions about involuntary hospital admission (Campbell, 2010; O’Hara *et al.*, 2013).

Various studies have highlighted the conflicting nature of using detention powers that undermine people’s freedom and liberty by practitioners/AMHPs, and in particular social workers, who champion a commitment to social justice, the empowerment of service users, and the promotion of recovery and social perspective ideals (Campbell *et al.*, 2006; Campbell and Davidson, 2009; Davidson and Campbell, 2007). While these principles are not necessarily incompatible with the practice of compulsory admission, the literature recognises the inherent tension (Abbott, 2018; Campbell *et al.*, 2006; Davidson and Campbell; 2009).

While the literature acknowledges the challenge AMHPs face to incorporate social perspectives into their detention decisions, the qualitative study - concerning MHA implementation - undertaken by O’Hare *et al.* (2013) raises doubt about whether this is what occurs during assessments. O’Hare *et al.* (2013) identified that their research subjects - including ASWs and social work trainees - adopted medical narratives, focussing on mental illness relapse and resistance to medication to justify intervention. Through case study vignettes and the results of a postal questionnaire, the paper offered insight into some of the key issues involved in MHA assessments and the decision-making processes of its assessors; however, the limited number of ASWs (only 3 from England) involved in the study may have affected the results, with social work trainees with limited practice experience comprising the majority of respondents. Notably, participants from social work backgrounds were asked to complete the survey absent of other key professionals from psychiatric backgrounds, creating less pressure to support a social model or position.

Similarly, Sheppard (1990) and Buckland (2016) observed that participants in their respective studies used people’s mental illness and medical narratives as the basis for detention. While it is common for MHA assessors to make decisions based on whether people’s medical conditions require hospital treatment, this analysis is usually framed within a culture where medical hegemony is infrequently challenged or subjected to critical investigation (Hall, 2017). Conversely, other studies identified that practitioners emphasised social circumstances for explaining crises and making such decisions (Peay, 2003; Hall, 2017). Peay (2003) explored how psychiatrists and ASWs reached detention decisions together using vignettes from case studies. She found differing positions from social workers, often deploying social perspectives to overrule a psychiatrist’s decision. The hypothetical case scenario adopted in her study may have impacted the results. In seeking to make sense of Peay’s findings, we must contextualise the environment and the circumstances under which participants were asked to make detention decisions. The ASWs were likely fully aware of their responsibility to locate social perspectives within an MHA assessment and implement this in the context of a hypothetical scenario. However, it is also possible that encountering real-life situations and faced with medical recommendations, the ASW participants may instead follow the statutory framework for involuntary admission by deploying medical or risk criteria in their decision-making.

The prominence of social perspectives in Peay's study is consistent with Hall's (2017) findings identifying that ASWs understood and interpreted crisis in a social context. Hall (2017) contends that the social worker role inhabited by most AMHPs complimented that of clinicians during mutual decision-making, applying the medical model alongside social perspectives. In this respect, all of a person's circumstances and experiences are taken into account; promoting service user participation and encouraging them and their families/carers to establish the underlining reasons for their crisis, instead of simply perceiving MHA assessments in medical terms (Tew, 2005). This requires the consideration of a broad range of concepts including shared decision-making; seeing the service user as an expert in their own condition and social capital. Practitioners ought to utilise these constructs to widen the assessment process, thereby helping to counterbalance the more restrictive perspectives of the dominant medical model (Hall, 2017). Importantly, Hall (2017) focussed on alternatives to compulsory detention, interviewing home treatment staff and ASWs involved in cases and MHA assessments resulting in home treatment or alternatives to hospital admission, likely impacting the study's outcome.

The implication of these studies with their contrasting findings raises questions as to the extent AMHPs can maintain an independent perspective, counterbalancing and challenging the medical viewpoint stipulated in the Code of Practice (DoH 2015). This is echoed by Campbell (2010), who highlights the concern that social workers may revert to the orthodoxy of medical narratives and the accompanying language of risk for detention decisions, rather than depending on their skills and knowledge.

Evidence suggests that social issues relating to housing, benefits, social networks, family, isolation, employment, marginalisation, inequalities, trauma, and social stigma may contribute to a person's mental health profile, and its ripple effect must be acknowledged when making detention decisions (Wickersham *et al.*, 2019; Hatfield, 2008). The impact of social issues on involuntary hospital admission is well-established in the literature (Hatfield, 2008; Campbell *et al.,* 2001; Manteklow *et al.*, 2002), with social factors closely linked to psychiatric problems (Campbell and Davidson, 2009; Thorncroft, 1991). Hatfield (2008) provides a convincing analysis of the impact of social factors on individuals assessed under the MHA. However, Hatfield's claim that mental health social workers occupy a unique position for identifying and providing interventions in response to these social issues has been disputed by O'Hare *et al.* (2013) who question whether AMHPs incorporate these social perspectives into their decision-making, given their observable focus on medical factors in detention judgements. Wickersham *et al.* (2019) state that informed decision-making - involving knowledge of the service users' background, social support network, community services, and easy access to resources - could help reduce hospitalisation; however, due to the role's high pressurised nature, practitioners may lack the capacity to try less restrictive alternatives to involuntary admission. Consequently, given the questions raised by the literature as to whether AMHPs apply social perspectives in their decision-making, I intend to explore this as part of an ethnographic study to examine decisions relating to the detention of Black people by AMHPs.

2.7 Alternatives to hospital admission/detention

A key part of the AMHP role is to challenge psychiatrists and be able to act independently, particularly concerning clinician advice, while identifying and assessing the relevant circumstances and exploring alternatives to detention (Stevens *et al.*, 2018).

Previous studies have indicated that admissions to psychiatric hospitals are often linked with a lack of community resources and viable alternatives to hospital admission (Quirk *et al.*, 2003; Wickersham *et al.*, 2019; Barnes, 1990). Wickersham *et al.* (2019) identified the availability of community resources, the provision of alternatives, and crisis services as central to avoiding hospital admission. Quirk *et al.* (2003) cited insufficient time for arranging alternatives as a contributing factor to admission, which is supported by Kinney's (2009) identification of pressure to address a crisis in a timely fashion.

The literature on the AMHP role has consistently shown uneven service provision engendered by resource problems (Davidson and Campbell, 2010), compounded by a preoccupation with risk and a requirement for evidence that risk minimisation is occurring (Coffey *et al.*, 2017). Within one of the few observational studies relating to decisions about involuntary hospital admission, Quirk *et al.* (2003) highlighted that the likelihood of a service user being detained increases when there are no realistic options for hospital admission (2003, p. 119). This study aimed to explore "non-clinical and extra-legal" factors influencing decision-making about involuntary hospital admission, using participant-observation of MHA assessments, including qualitative interviews with the practitioners involved, and follow-up interviews with the service users being assessed. The study revealed that several factors contributed to decisions about detention. The non-clinical influences included limited time for organising alternatives to admission and a lack of support from other professionals, while the extra-legal influences involved organisational factors and professional accountability resulting from detention decisions. The study concludes that non-clinical and extra-legal influences account for some of the geographical variations in detention rates. According to Quirk *et al.* (2003), if detention is considered a last resort, policy makers must prioritise allocation of resources and service organisation, rather than focusing on legislative change. Through observation and interviews with mental health professionals, including ASWs, the aforementioned study's relevance lies in its exploration of how decisions are made concerning involuntary admission. However, exploring the nature of AMHP practice when detaining Black people was not part of the study's objectives. Its focus on the influence of organisational factors - such as limited resources and service organisation - on practitioner's decision-making provides an insight into how judgements are made in real-life situations. Nonetheless, it is also possible that like time constraints, organisational factors affect the provision of alternatives to hospitalisation (Abbott, 2018).

Kinney (2009) identified that AMHPs are hindered by a lack of alternative resources, a position shared by Hall (2017), who highlighted how an ASW's only available option was to admit the person assessed. Hall optimistically places the ASW as a dealmaker when exploring community resources (Hall, 2017); however, the literature identifies the deterministic nature of the lack of alternatives to detention (Stone, 2017; Glover-Thomas, 2018; Buckland, 2016; Quirk *et al.*, 2003).

Hall (2017) identified service users' willingness to engage with an assessor and services, such as the home treatment team, as a basis for avoiding involuntary admission. Thompson (1997) reinforces this, rationalising a service user's cooperation and engagement with the ASW as significant to the detention decision. Hall's (2017) study focused on assessments in which home treatment services or alternatives to hospital admission were in consideration, and therefore, may have impacted the outcome. Abbott (2018) focused on an assessed person accepting their mental health status and illness and the AMHP's willingness to trust the person to take medication being significant to the decision. This was reaffirmed by Stone (2017) who identified compliance with medication as a relevant factor in such decision-making. Abbott (2018) identified that if the service user was unwilling to cooperate with the alternative plan, risks would be deployed to rationalise detention decisions.

Informed decision-making could help reduce hospitalisation (Wickersham *et al.*, 2019). It is also highlighted that knowledge of a service user's background, social support network, community services, and easy access to resources can all be considered when deciding on detention (Hall, 2017). However, due to the high-pressure nature of the role, practitioners may lack the time to try a less restrictive alternative to involuntary admission (Wickersham *et al.*, 2019). This is supported by Langan's (1989) study identifying that the inadequate timeframe for completing MHA assessments can prove problematic, with practitioners missing opportunities to "reflect-in-action" (Schon, 1987) or to consider alternatives during the decision-making process.

Langan (1989) identified that besides the absence of alternatives to hospitalisation affecting detention decisions, the ASW participants in her study often lacked a clear understanding of the medical and socio-legal factors that their role enjoined them to consider when applying compulsory powers.

2.8 Black people and compulsory detention under the MHA

Studies have consistently shown that people from Black communities are more likely to be assessed for compulsory admission to psychiatric hospitals (NHS Digital, 2021; DHSC, 2018; Bhui and O'Hara, 2014; Webber and Huxley, 2004). Exploring the practice of ASWs, Hatfield (2008) illustrated how some social groups - including people from Black communities - were disproportionately affected by the use of detention powers. This was compounded by the fact that the individuals undergoing MHA assessment were often faced with multiple social disadvantages such as isolation, unemployment, marginalisation, low income, and social exclusion (Campbell, 2010). People from Black communities account for only 12% of the population in England and yet experience poorer outcomes across all health, social, and well-being indicators (Keating, 2016). The 2011 census by the Office of National Statistics (2012) revealed that Black people experience disproportionately higher rates of unemployment, poorer health, and continue to experience frequent racial harassment.

Evidence shows that Black people have inferior experiences and poorer outcomes within the mental health system (Bhui and O'Hara, 2014). They are less likely to receive primary care intervention; more likely to end up in crisis care, more likely to be compulsorily admitted into hospital, and more likely to access mental health care through the criminal justice system (Bignall *et al.*, 2019). Studies have reported that Black people have higher rates of diagnosis of schizophrenia (Fernando, 2017; Bignall *et al.*, 2019) but are less likely to be offered psychological therapies (DHSC, 2018; Bhui and O'Hara, 2014). Therefore, there is compelling evidence that once within the mental health system, Black service users are overwhelmingly disadvantaged in terms of their mental health care and treatment experiences (Bhui and O'Hara, 2014; Nacro, 2007).

The Independent Review of the MHA (DHSC, 2018) noted that despite the existence of the Equality Act 2010, public institutions and organisations have struggled to discharge their public sector duties concerning equal treatment for all. Considering that people from Black African and Caribbean backgrounds receive disproportionately low rates of community mental health care, low uptake of talking therapy and counselling support, higher rates of detention, and greater risk of being detained in secure and psychiatric intensive care units (PICUs), this group experience ongoing disadvantage in terms of the protected characteristics of race.

Institutional racism, prejudice, and discrimination are often cited as the cause of the overrepresentation and ethnic inequalities in mental healthcare, as well as economic and social outcomes (Bhui *et al.*, 2018; Fernando, 2010). This was reinforced by the independent MHA review (DHSC, 2018) highlighting how organisational and structural factors generate stigma, negative stereotypes, and racism, increasing the likelihood of differential experiences for Black people. It concluded that the source of rising rates of detention in Black people was "multifactorial, involving longstanding experiences of discrimination and deprivation, with a lack of understanding of the human dynamics of what is happening and some crucial gaps in trust between service users and providers" (DHSC, 2018, p. 20).

Utilising semi-structured interviews with twelve self-identified Black inpatient service users, and adopting a critical realist research paradigm, Solanki's (2020) study explored the experiences of Black people detained as inpatients under the MHA. This research identified four overarching themes: help being decided by others and not tailored to the service user; not being treated as a person but rather as a "Black patient"; mistreatment or neglect instead of care; and sectioning as a potential space for sanctuary and support. The study concluded that Black service users endured distinctive experiences of compulsory admission that were "racialised and racist" (p. 7). While the study illuminated insights into the lived experience of Black people detained as inpatients under the MHA, it lacked observations of the actual assessments and the interaction between AMHPs and service users which are of particular interest to the present study.

Fernando (2010) argues that mental health practice is characterised by four features: firstly, the failure of most professionals to challenge race-based discrimination and institutional racism in mental health services; secondly, the structural racism inherent in mental health assessments; thirdly, the social disadvantages that Black people overwhelmingly face not being recognised by professionals, for example, a service user's reasonable frustration and exasperation in response to societal racism is not taken into account when completing an assessment; and fourthly, the alienation, isolation, and discontent felt by many Black people being interpreted as a sign of mental illness. Fernando (2010) concludes that the net result of this is that Black people are disproportionately represented in both the criminal justice and the mental health services. The racism experienced by Black people in wider society aggravates already poor outcomes and their mental health care experiences. It is argued that racial discrimination is a defining characteristic or hallmark of both a Black person's detention experience and their everyday lives, epitomised by police involvement in their care pathways (DHSC, 2019c).

One of the contributing factors to the inequalities and disadvantages that Black people experience in mental health care is the "risk agenda" which for many years has remained central policy in the mental health service (Keating, 2009, p. 6). Fennel (2007) contends that as a consequence of concerns and anxieties about homicides by people suffering from mental disorders, various governments have followed a risk or public safety agenda. This appears racialised and gendered, in that young Black males in particular are perceived by professionals as ‘dangerous’ and therefore presenting a risk to the public. Irrespective of their history of aggression or violent behaviour, young Black men epitomise the high-risk category. This stemmed partly from the inquiry into Jonathan Zito’s murder by a young Black service user called Christopher Clunis (Ritchie *et al.*, 1994) and how Clunis was constructed as the quintessential ‘high-risk’ character in mental health provision (Warner, 2007). As the literature highlights, the stereotypical attitudes of people towards young Black men in particular as being “big, black and dangerous” were established following the popular perception of the Clunis case (Keating, 2009, p. 6). Beliefs about dangerousness generate fear, avoidance, and punitive intervention (Corrigan *et al.*, 2002; Keating *et al.*, 2002); with this perception of young Black men often resulting in the belief that such people were less deserving of interventions leading to recovery pathways (Keating, 2009; Patel, 2014). Therefore, it can be expected that this particular social group experiences more restrictive and punitive aspects of mental health care (Rogers and Pilgrim, 2014, Nacro 2007, Bhui *et al.*, 2018).

In the aftermath of the Clunis case, public anxiety about the management and control of people with severe mental illness led to the creation of supervision registers and supervised discharge, facilitating the strict monitoring of people at risk of relapse following hospital release (Davies, 2012). However, these registers were inconsistently applied (Bindman *et al.*, 2000), with evidence that supervised discharge was disproportionately applied to Black people, particularly African-Caribbean service users (Hartfield *et al.*, 2001). This heightened the monitoring of Black people in the community as a consequence of their perceived risk to others.

Despite the longstanding nature of the problem highlighted in the literature (Fernando, 2017; Bhui *et al.*, 2018), little is known about the role of the social worker/AMHPs holding decision-making responsibility for detaining Black people. Keating (2016, p. 180) has argued that mental health social work appears “complicit and silent about issues of race”. While emphasising the argument found in the literature that mental health social workers are expected to possess the skills and knowledge for recognising and challenging aspects of the law that discriminate against groups confronting social disadvantage, Campbell (2010) questions how such an awareness can be demonstrated in practice. This necessitates further observational studies in this area for a better understanding of how AMHPs arrive at their detention decisions, particularly concerning people from Black communities who are over-represented within the mental health system but continue to experience racial inequalities within it. This research seeks to fill this knowledge gap.

2.9 Conclusion

In summary, this critical review of the literature on the AMHP role and the decision-making process relating to detention has identified five main themes. Risk emerged as an overarching subject, driving AMHP decisions about compulsory admission. One of the main objectives of the MHA is to ensure that decision-making consciously minimises the risk of negative outcomes resulting from mental disorders by increasing safety and welfare. Theoretically, framing decisions around risk discourses between professionals may achieve this by deploying compulsory powers under mental health legislation, whereby an individual presents a risk to themselves and others. However, as is clearly shown in this review, this focus on risk in decision-making has proven a subjective exercise, tending to be inconsistent and problematic. As Coffey *et al.* (2017) noted, the requirement for professionals to assess and manage risk may fail to meet policy objectives because of poor prediction skills and a fear of bad outcomes resulting in risk-averse and defensive practices. While the reviewed studies consistently exposed the subjectivity of AMHP risk decisions, the question of how these professionals constructed risk when arriving at a decision was often beyond their purview and remains unanswered. The analysis of the literature also revealed that accountability is inextricably connected to risk, with various studies identifying fear of professional responsibility when risk-taking. The literature highlighted that practitioners' anxiety about their accountability for negative outcomes occurring, public scrutiny, and 'blame culture' affect their detention decisions. In other words, a fear of consequences leads to AMHPs considering risk-averse options. While the MHA encourages AMHPs to produce independent decisions, this review has shown that organisational factors and management pressure affect decisions about detention amid practitioner perceptions of accountability.

Involuntary hospital admissions are often linked with a lack of community resources and suitable alternatives. The literature has consistently shown uneven service provision engendered by resource problems, compounded by a preoccupation with risk and the need for evidence of its minimisation occurring. Consequently, AMHPs work within the context of organisational factors, blame culture, limited resources, and a lack of viable alternatives to hospitalisation, ultimately placing practitioners under considerable strain. This means that in terms of risk assessment and management, they are more inclined to engage in risk-averse and defensive practices.

The MHA Code of Practice (DoH, 2015) stipulates social perspective as an important feature of AMHP work. This implies that practitioners should commit to evaluating people’s voices, social circumstances, and experiences contrary to a medical model focused on symptoms and risk. Despite the centrality of social perspectives in AMHP practice, there are challenges to its implementation when considering structures within an organisation and the concept of risk, both invariably understood to be deeply rooted in AMHP decision-making.

There is overwhelming evidence within the relevant literature that people from Black communities are likelier to be assessed for detention, and this is compounded by the fact that Black people are often faced with multiple social disadvantages such as isolation, unemployment, marginalisation, low incomes, and social exclusion. Despite the problem’s longstanding presence within the literature, there has been a lack of direct observational studies into the actual practice of assessing Black people for compulsory admission. According to Campbell (2010), while mental health social workers are expected to have the skills and knowledge to recognise and challenge aspects of the law that discriminate against particular social groups encountering disadvantages, it is unclear how such an awareness can be demonstrated in practice. This demands further observational studies for a better understanding of how AMHPs arrive at their detention decisions, particularly concerning people from Black and Minority Ethnic communities who are over-represented within the mental health system. This research seeks to fill this gap.

This review shows there is a deficit in knowledge about the actual practice of assessing people - particularly those from Black communities - for detention. The critical analysis of the literature related to AMHP decision-making reveals a dearth of direct observational studies into how practitioners form judgements about detention or the nature of interactions that occur between practitioners and Black service users. The themes discussed in this review highlight that AMHP detention decisions heavily concentrate on risk, however, the theoretical foundation of these risk decisions is underdeveloped, and its implication for Black people lacks conceptualisation. It is also noted that AMHPs' preoccupation with risk during MHA assessments ultimately impacts their value commitment to incorporate social perspectives into their judgements. While this review presents several findings and themes contributing to knowledge about the AMHP role, it reveals disparities between practitioner and service user perceptions of risk, treatment, and care, and how service users encounter or experience it. This research seeks to address this gap in the literature by answering how service users understand their experiences of detention and community services.

The main research questions generated from this literature review are outlined below:

1 How are the decisions relating to detention made by the AMHPs - and what influences their judgements?
2 In what ways do practitioners think about and construct risk when arriving at a decision?
3 What account do professionals take of the knowledge, circumstances, and experiences of service users?
4 What are service users' perspectives of their experience of detention and community services?

Having reviewed the relevant literature and presented the research questions, in the following chapter, I will discuss the theoretical framework informing this research.

Chapter 3: A Theoretical Framework

3.1 Introduction

This chapter presents a discussion of the theoretical framework I will use to explore the work of the AMHP and their face-to-face encounters with Black mental health service users. I draw on the applied sociological concepts of ‘risk work’ and ‘epistemic injustice’ to understand AMHP practice. Throughout the discussion, I will attempt to combine and integrate ‘risk work’ and ‘epistemic injustice’ concepts into a single framework informing my empirical work, while explaining the importance of each in the context of my study.

3.2 Risk work theory

Risk work is one of the key concepts I employ to construct the theoretical framework for this study. Brown and Gale describe this as:

> …the practices of professionals (and those assisting professional work) dealing directly with clients, where the management of risk – through assessing, intervening, advising and/or communicating – has become a key and (in some cases) (re)defining logic of everyday work (Brown and Gale, 2018a, p2).

Horlick-Jones (2005) conceptualises risk work as the practical ways in which professionals manage uncertainty and risk in their daily practices, within the context of organisational power dynamics. While Horlick-Jones and Power (2016) centre practices in terms of organisational power structures and the protocols emerging from them, Brown and Gale (2018) concentrate on practitioners' lived experiences and their professional identities, analysing the ways in which these related to their daily practices while situated within "wider organisational and (para)professional power dynamics" (p. 1). Brown and Gale (2018) similarly highlight "front-line" work where professionals engage in face-to-face interaction with service users, and require the interpretation of bureaucratic protocols on risk, using higher or limited levels of discretion.

Frontline professionals must have risk knowledge and apply it in their everyday practice intending to make justifiable decisions and risk interventions (Brown and Gale, 2018). Risk knowledge consists of standardised risk procedures or formal probabilistic analysis, alongside a person's implicit knowledge and intuition (Harrits, 2016; Brown and Gale, 2018; Chivers, 2018). Professionals utilise these to inject certainty to manage realistic perceptions of risk with the uncertainties of face-to-face work (Brown and Gale, 2018; Gale *et al.*, 2016).

Gale *et al.* (2016) outline the three key elements of risk work: translating risk knowledge into specific contexts, putting in place action plans to mitigate risks where there is uncertainty, and offering support to individuals within this framework. Brown and Gale (2018) divide the social dynamics of risk work into risk knowledge, interventions, and social relations, connected through the lived experiences of practitioners, and how these relate to their daily practices within the context of organisational and professional power dynamics. Frontline risk work involves taking risk knowledge - as understood at a population level - and translating it for the individual environment (Heyman, 2010). This can create tensions for the professional when applied to individual cases. Having deemed an incident or behaviour as risky, they will then need to conduct some form of risk intervention. The third feature, social relations, recognises that relationships and interactions are at the heart of a professional's experience of risk work. According to Brown and Gale (2018), tensions may arise between the elements of social relations and risk intervention, for example, if the latter adversely affects the client relationship resulting in suspicion, mistrust, and nonengagement. As a result, this may undermine a professional's ability to understand the risks concerning an individual or a particular social group (Heyman *et al.*, 2012; Brown and Gale, 2018). Figure 1 depicts the three core features of risk work.

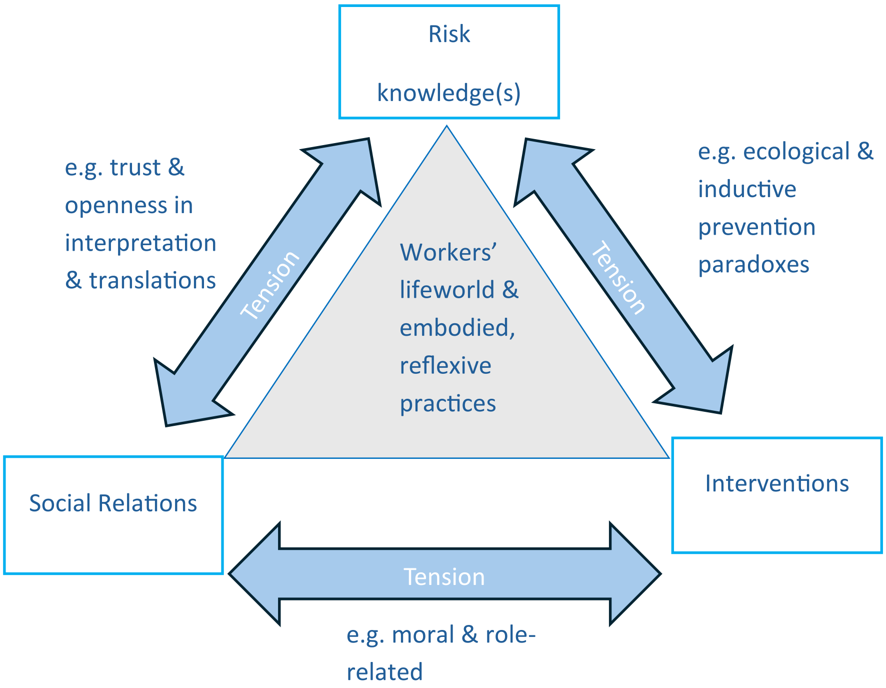

Figure 1. Core concepts and tensions in risk work (Brown & Gale, 2018)

While it is commonly assumed that risk knowledge is first generated and then transferred into daily risk management practices, it has been argued that risk continues to be "constructed and reconstructed" (Brown and Gale, 2018 p.3) within the context of an organisation and interactions (Hautomaki, 2018; Farre *et al.*, 2017). Risk work could be an important concept in this research for linking theory and practice, providing a useful tool to grasp how AMHPs make detention decisions that heavily rely on risk assessment, the impact of the preoccupation with risk on their role and professional autonomy, and its implications for Black service user experience.

Risk work is at the heart of AMHPs' day-to-day practice (Stanley, 2018; Chivers, 2018). AMHPs identify, assess, and handle behaviours considered risky (Gale *et al.*, 2016), while making decisions about individuals suffering from mental illness. Under the MHA 1983, AMHPs serve as agents of the state assessing and intervening in vulnerable people’s lives by safeguarding their risk of harm to themselves or others. AMHPs hold a legal mandate to conduct MHA assessments – with their working practices framed by concepts of risk (Gale *et al.*, 2016). AMHPs are therefore “in the business of risk work” (Stanley, 2018, p. 104), in this context defined as an attempt by professionals (AMHPs) to manage the uncertainties associated with mental illness within their everyday work, employing their implicit knowledge or judgement together with standardised risk procedures (Gale *et al.*, 2016, Harrits, 2016).

High-risk narratives are powerful and often perceived as fixed attributes of mental health service users, and this can create oppressive and risk-averse practices (Stanley, 2018). Unquestionably, this preoccupation with risk affects detention decisions, and risk work can be applied to practice-informed studies within the AMHP service (Stanley, 2018). For example, if there is a conflict between a practitioner and a service user as to how a particular behaviour is conceived or interpreted, how can a practitioner implement social worker values/ideals by sharing power in knowledge production with the service user? Risk work highlights the space in decision-making for values and moral judgement, and the subsequent need for its consideration alongside epistemic injustice, which I will discuss in the following section.

The concept of risk work can aid in questioning why social workers encounter many challenges when dealing with risk in mental healthcare in terms of risk information, the nature of the intervention, and the relationship between practitioners and service users (Gale *et al.*, 2016). Risk work could also help to explore the strategies that frontline professionals - such as AMHPs - adopt to help them deal with the tensions, uncertainties, and anxieties they encounter in their everyday practices (Stanley, 2018). Accordingly, risk work is a potentially useful conceptual framework to explore how approved mental health professionals make detention decisions in their day-to-day practices.

3.4 Epistemic injustice

Another concept I utilise for constructing a theoretical framework is Fricker's (2007) idea of epistemic injustice, offering a theoretical basis for exploring AMHP work and service user detention experiences characterised by unequal power dynamics that privilege professional authority and knowledge over lived experience. I identified the relevance of Fricker's work to my study after searching for alternatives for understanding the decision-making process for detaining Black service users. This includes evidence of the injustices embedded in MHA assessments; complaints by Black service users about lacking a voice or involvement in decisions relating to their care; and the disconnect between how professionals view their interventions and how this is experienced by the service users involved. I felt Fricker's framework of epistemic injustice resonated with some of the research questions that emerged from the literature review.

Exploring the relationship between power and our understanding of social experiences, Fricker discusses how epistemic injustice impedes certain groups from challenging distorted understandings of their social experiences (Fricker, 2006). Centring the impact of power and social identity on individuals' social understanding and status as "knowers", Fricker distinguishes epistemic injustice is "a wrong done to someone specifically in their capacity as a knower" (Fricker, 2007, p.1). This harm - inflicted on people in their capacity as reasoners, speakers, inquirers, communicators, and knowers - is a distinguishing feature of epistemic injustice (Radoilska, 2020; Fricker, 2007). Formed around how a person possessing knowledge can be unfairly denied the opportunity to impart this to others or make sense of their experiences (Fricker, 2007), its harm occurs through a person's exclusion from knowledge building (Scrutton, 2017).

Epistemic injustice underpins other forms of social injustice because contributing knowledge and participating in inquiry is essential to human worth and value (Fricker, 2007; Medina, 2013). This identifies that prejudice based on negative stereotypes associated with a particular social group results in discrimination against individuals in their capacity as knowers (Fricker, 2007; Byskov, 2020; Newbigging *et al.*, 2018). Fricker argues that epistemic injustice is detrimental to its victims, particularly as a consequence of prejudices against their identity, such as race and gender (Fricker, 2007).

Considering that obtaining and giving knowledge is intrinsic to our human value, it should be predictable that in the context of oppression, the dominant party may continue to harm those lacking power by way of undermining this form of their humanity (Fricker, 2007; Medina, 2013; Price, 2011). Inequality is a violation of knowledge; it hinders our ability to know and advance our understanding of others

(Medina 2013). Medina (2013) argues epistemic and social injustice are closely related, always moving in tandem, and mutually reinforcing one another. Social injustices engender epistemic injustice by undermining knowledge-sharing relationships between disadvantaged social groups - who are unfairly regarded as intellectually inferior - and their privileged counterparts (Medina, 2013).

Fricker identifies testimonial and hermeneutical as two types of epistemic injustice. Testimonial injustice occurs when a person’s credibility is undermined, and their word – or testimony - is dismissed or disbelieved because of negative stereotypes associated with a particular social identity (Fricker, 2007), common examples including racism, sexism, and prejudices against people with mental illness (Crichton *et al.*, 2017). Consequently, testimonial injustice arises when an individual lacks credibility due to identity-based prejudice (LeBlanc and Kinsella, 2016; Fricker, 2007) resulting in someone’s narrative being determined unreliable, and undermining their status as knowers (Crichton *et al.*, 2017). Fricker explains how such injustice can harm a person, particularly when caused by stereotypes connected to characteristics determining their identity, such as race and gender. She discusses how these stereotypes unjustly diminish the credibility of women and people of Black and minority ethnic descent, such that their accounts are dismissed or ignored, as they are treated as unreliable (Fricker, 2007). Since holding the capacity to give information or knowledge to others is essential to social life, testimonial injustice inflicts harm on individuals who experience it (LeBlanc and Kinsella, 2016; Fricker, 2007).

Fricker stresses that a person suffers from a testimonial injustice only if they lack credibility as a consequence of others’ identity-based prejudice. Focusing specifically on cases possessing what she termed an “identity-prejudicial credibility deficit” (Fricker, 2007, p.28), Fricker acknowledges that prejudice can be positive but centres her discussion around damaging stereotypes relating to insufficient rather than excess credibility. Fricker defined a negative identity-prejudicial stereotype as:

> …a widely held disparaging association between a social group and one or more attributes, where this association embodies a generalisation that displays some (typically, epistemically culpable) resistance to counter-evidence owing to an ethically bad affective investment.

Critiquing Fricker's classification of testimonial injustice, Jennifer Lackey (2020) argues that in certain circumstances a prejudicial credibility deficit is not enough to fully explain or encapsulate potential failures during an evaluation judging credibility. In her work 'False Confessions and Testimonial Injustice', she highlights the trustworthiness assigned to a suspect the moment they give a false confession under interrogation. When a suspect's confession achieved through coercion, manipulation, and sleep deprivation, "represents her truest self, the confessor's status as a knower is reduced to what she reports only under conditions devoid of, or with diminished epistemic agency". Lackey (2020) suggests that the conceptualisation of testimonial injustice requires an expansion including what she calls "agential Testimonial Injustice" whereby "an unwarranted credibility excess is afforded to speakers when their epistemic agency has been denied or subverted in the obtaining of their testimony" (Lackey, 2020, p.43). Using cases of false confession during police interrogation, Lackey discusses several "dispositional factors" leaving a suspect unfairly susceptible to providing a false confession, identifying juvenile status and mental impairment as the two most common features (Lackey 2020, p. 48). Being innocent, young, or experiencing a mental disorder of any kind leaves one particularly susceptible to pressures under police interrogation, culminating in confessions achieved under severe emotional and physical distress. In despair and agony, some innocent confessors will respond to a positive declaration of short-term comfort and relief from the interrogation situation. Consequently, Lackey argues that both credibility deficits and excesses may amount to testimonial injustice. Similarly, Jose Medina (2013) maintains that credibility excess may also result in epistemic injustice, further challenging Fricker's view that such injustice arises solely from credibility deficits.

Hermeneutical injustice arises "when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p.1). It is a harm caused to groups of people in their status as subjects of social understanding through structural prejudices which affect conceptual resources necessary to make sense of their experiences (Medina, 2013; Fricker 2007; Hookway, 2010). Fricker states that an individual suffers hermeneutical injustice when they lack interpretive or conceptual resources needed to understand their experiences. She provides an example of how a person who lacks social understanding and the concept of sexual harassment may lack the capacity to interpret or articulate their experience when they are victims of such behaviour (Fricker, 2006). This partly stems from prevailing social norms privileging a particular kind of knowledge (Newbigging and Ridley 2018). Arguably, there is a failure to appreciate the value of service users' perspectives on knowledge production profoundly embedded within mainstream discourses (LeBlanc and Kinsella, 2016; Rimke and Brock, 2012), such that epistemic injustice is often perpetuated without recognising the potential harm to its victims (Fricker, 2007).

Furthermore, epistemic injustice occurs when people are prohibited from participating as epistemic agents because they lack recognition as knowers (Hookway, 2010). This is an epistemic exclusion, taking place when prejudice creates a propensity for a particular social group to be initially overlooked when sharing information. Epistemic exclusion intersects with testimonial injustice through those social groups experiencing or subject to identity prejudice becoming vulnerable to unwarranted credibility deficit, and likewise, will simply tend to be disregarded amid information sharing, with their views, opinions, and judgements often left unsolicited. Fricker asserts that this type of testimonial injustice reproduces in silence, with the prejudice of others fulfilling its purpose prior to any potential communicative exchange. Fricker calls this “pre-emptive testimonial injustice”, occurring when a subject is not invited to share any information due to their preconceived unreliability, and silenced by the marginalisation of others who disregard their knowledge, views, and assertions owing to identity prejudice. Fricker asserts that this is the most persistent kind of epistemic injustice (Fricker, 2007, p.130).

In his work ‘Epistemic Injustice and Mental Illness’, Scrutton (2017, p. 350) notes:

> “…the silencing that is a structural facet of psychiatric diagnosis and treatment is, in and of itself, deflating, and likely to effect a transition from experients being active agents to being passive recipients – in other words, becoming healthcare consumers rather than participants, and objects rather than subjects”.

Dotson (2011) argues that silencing or epistemic violence is founded upon communication as mutual exchanges arising from when a hearer ignores or fails to account for the vulnerabilities of the speaker (Dotson, 2011). This failure is a product of social norms, negative stereotypes, and structural impediments hindering participation, creating a lack of awareness and affecting appreciation of epistemic agency (Dotson, 2011). Unjustly denying or attributing reduced credibility to someone on a negative prejudicial basis associated with their social identity is a form of testimonial injustice; denying someone a role as a participating or contributing epistemic agent is a distinct form of epistemic exclusion (Hookway 2010).

When determining information, particularly about risk, there is a presumption in favour of expert knowledge due to a social hierarchy ascribing it to a higher epistemic status

(Carel and Kidd, 2014), with professionals frequently defining a service user's knowledge to be irrelevant during discussions and risk assessments. Service users become objects of epistemic practices of risk instead of being regarded as participants within them (Carel and Kidd 2014), becoming further marginalised by the disrespect shown to their knowledge-giving potential, which Fricker considers an essential measure of human value (Fricker, 2007; Medina, 2013).

Carel and Kidd (2014, p.16) observe that epistemic injustice can manifest in response to the privileged status enjoyed by professionals by virtue of their training, expertise, and objective data, to "occupy [an] epistemically privileged role" when assessing risk and making judgements about whose testimonies and knowledge are worthy of consideration. The structures of modern mental healthcare and the dominant biomedical model generate or produce epistemic injustice by privileging objectivity, impersonal third-person accounts, and particular ways of presenting testimonies or sharing information that structurally undermines service users' testimonies or assertions (Carel and Kidd, 2014; Scrutton, 2017). Consequently, contemporary mental healthcare favours empirical evidence provided by professionals over the lived experiences and accounts of its service users. Carel and Kidd (2014) identify that many professionals should endeavour to allow for service users' testimonies, views, and assertions; however, they acknowledge the constraints and pressures of time, policy-orientation, and protocol-driven practices within organisations.

Another way of conceptualising this injustice is as a form of epistemic objectification whereby a person's testimony is neither sought nor trusted; only able to contribute to knowledge production as an object of epistemic activity, or as a source of information rather than as an informant (Dohmen, 2016, Scrutton, 2017). Carel and Kidd (2014) observe that patients are overlooked as subjects of potential knowledge but rather as objects of investigation; specifically, service users are prohibited from demonstrating expertise about the issues that matter to them. Carel and Kidd (2014) remark that an ill person may be seen as:

> "…cognitively unreliable, emotionally compromised, existentially unstable or otherwise epistemically unreliable in a way that render their testimony suspect simply by virtue of their status as an ill person with little sensitivity to their factual condition and state of mind".

The psychiatric hegemony and the dominance of the biomedical model have marginalised alternative perspectives and analyses of mental illness, excluding patients' experiences and perspectives from epistemic activities (LeBlanc and Kinsella, 2016; Newbigging and Ridley, 2018). Individuals experiencing mental health issues are particularly vulnerable to epistemic injustice because negative stereotypes and social stigma lead to their credibility being discounted and devalued (Crichton *et al.*, 2017). Consequently, they are denied the opportunity to participate as epistemic agents during decision-making about their lives, raising the likelihood of compulsion or detention (Scrutton, 2017, Crichton *et al.*, 2017). The importance of epistemic injustice to the AMHP role lies in its potential for recognising unequal power dynamics within MHA assessments, whereby the professionals use their discretion and powers to determine whose knowledge and interpretations of risk are worthy of epistemic consideration.

Fricker (2007) identifies epistemic injustice as the prevailing yet primarily silent feature of discrimination. This is potentially useful to this research as it may add another layer of understanding to service users' detention experiences, particularly those from Black communities who are four times more likely to be detained under the MHA (Mohdin, 2021). The recent independent review of the MHA 1983 (DHSC, 2018) emphasised that epistemic injustice is present in service users' experiences of the detention process. Service users reported that when raising valid concerns or describing the trauma detention caused them, their accounts were dismissed as symptoms of mental disorder (Costa *et al.*, 2012). The impact of epistemic injustice in psychiatry is particularly profound as regards the MHA (Sanati and Kyratsous, 2015), specifically for people of African and Caribbean descent experiencing the dual stigmatisation of being Black and having a mental illness diagnosis (Wilkinson, 1998), and inequalities in patient-centred care.

3.4.1 Broadening epistemic considerations – the possible ways of addressing epistemic injustice

One of the possible ways of addressing epistemic injustice requires the development of epistemic humility and the ability of the listener to cultivate greater insight and awareness of the potential epistemic injustice and inequalities within interactions between practitioner and service user (Newbigging and Ridley, 2018; Crichton *et al.*, 2016; Carel and Kidd, 2014). Fricker (2007) argues that overcoming epistemic injustice requires listeners - in this case, practitioners - to make a conscious effort to actively practice granting service users greater credibility. Scrutton (2017) recommends adopting a position of listening instead of “knowing best” to help reverse the stigma, sense of exclusion, and diminished control and choice that people with mental health problems continue to experience.

Another solution rooted in service user perspectives centres on the empowerment and strengthening of the agency of mental health service users (Newbigging and Ridley, 2018). This aims to communicate the perceptions of epistemically marginalised individuals, challenging dominant narratives and neoliberal constructions of individualism while leaving space for alternative knowledge and understandings of different mental illness experiences and care strategies (LeBlanc and Kinsella, 2016; Medina, 2012). Originating from psychiatric survivors and service user activism, mad studies proposes political involvement, a recovery-oriented approach, and advocacy; legitimising service user accounts and experiences as a basis for a different paradigm and epistemological foundation for mental illness (Beresford and Russo, 2016; Newbigging and Ridley, 2018). Independent mental health advocacy can also validate and recognise mental health service users as epistemic agents, helping to promote epistemic justice by strengthening voices, supporting participation in decision-making, and tackling “prejudicial-credibility deficits” (Newbigging and Ridley, 2018).

The concept of epistemic injustice can be incorporated into the framework for investigating the level of service user participation during decision-making about their care and treatment in the MHA assessment context. This concept’s contribution to this research occurs by providing a useful tool for analysing people’s direct accounts of their detention experiences and encounters or interactions with social workers/AMHPs engaging in risk work. Further evidence of the importance of epistemic injustice in AMHP practice can be observed in the potentially one-sided or unequal relationship between the AMHP and the person undergoing assessment, where a practitioner may solely rely on their knowledge and power to interpret what is considered ‘risky’, and making interventions which could profoundly impact the individual.

Fricker’s work has undeniably stimulated valuable discussions about the intersection of knowledge and power. However, some scholars argue that certain aspects of her theory could be further developed or refined to better capture the nuances of epistemic injustice. Fricker’s emphasis on individual epistemic virtues as a remedy for epistemic injustice has been criticised for neglecting the broader structural and systemic dimensions of epistemic injustice (Bufkin, 2024). For example, deeply embedded factors - such as racialised social narratives and institutional biases - perpetuate epistemic injustices in ways that cannot be addressed simply by enhancing individual epistemic efforts or practices (Bufkin, 2024).

Additionally, Fricker's concept of hermeneutical injustice is seen by some as placing excessive weight on social conditions, potentially conflating epistemic injustice with other forms of social disadvantage. This has led to calls for a more distinct boundary between epistemic and non-epistemic injustices (Beeby, 2011).

3.5 Integrating risk work and epistemic injustice perspectives into a framework

To inform this research, I have integrated risk work and epistemic injustice concepts into my theoretical framework. Combining elements of both, I intend to compensate for the individual limitations that may arise when each is used in isolation from the other. No single aspect of the research framework can provide a full understanding or complete picture of the MHA assessment process which is characterised by preoccupations with risk, unequal power dynamics, and the tensions emerging during epistemic interactions and informational exchanges. For example, analysing risk work may help illustrate how frontline professionals – AMHPs - construct cases and use risk knowledge to assess and consider the appropriateness of interventions, but without utilising an epistemic justice context, this will fail to delve into the potential power asymmetries within mental healthcare that privilege professional authority and knowledge over lived experience. These two theories are integrated into a framework for explaining what transpires during interactions and exchanges, which Brown and Gale (2018a) call the communicative aspect of client-facing risk work. This shapes how AMHP practice entails using individual expertise to assess, interpret, and translate risk knowledge, interacting with service users, forming judgement about risk, and conveying information; using their power, discretion, and privileged position to determine user participation in their treatment decisions, and whose knowledge or interpretation of risk is worthy of epistemic consideration. I use this theoretical framework as a lens for examining AMHP work - with all its nuances, complexity, and the uncertainty involved when dealing with individuals and different social circumstances - connecting these two concepts by providing distinct focuses within the same structure. Each aspect performs distinct functions concerning knowledge production and understanding.

- A risk work perspective (Gale *et al.*, 2016; Brown and Gale, 2018) provides an understanding of how professionals use their knowledge of different types of risk translated into specific contexts; engaging in communication exchanges, interacting with clients, and identifying appropriate responses and intervention.
- Risk work combines the components of risk knowledge, social relations, and intervention. The social dynamics of risk work generate tensions and sometimes create new risks.
- Embedded in risk work are the moral features of holding individuals accountable (Brown and Gale, 2018), and how the practitioner manages this can either promote or damage trust relations, working alliances, and communication (Brown and Calnan, 2013), impacting a professional's understanding of the risks concerning an individual or a particular social group (Brown and Gale, 2018).

- Epistemic injustice provides an understanding of knowledge production; the power dynamics, social position, and status in an interaction and relationship context; the level and nature of participation in epistemic practices; and who is considered a non-knower during the communicative phase of client-facing risk work, receiving lower credibility because of their identity or social position.
- Risk work and epistemic justice/injustice are combined to identify the strategies that AMHPs adopt to help deal with tensions affecting client relationships, with epistemic justice coupled with social work ideals espousing power sharing in knowledge production with service users (Stanley, 2018).
- Epistemic injustice may ease the tensions found in client-facing risk work by using listeners, with AMHPs consciously offering greater credibility to service users, or what Fricker (2007, pg.1) terms “testimonial justice”.

3.6 Conclusion

In summary, I believe combining these two theories into the outlined framework could provide a potentially strong theoretical basis for exploring AMHP practice. The individual components of this are connected via the AMHP role; drawing on risk work relates to the task of assessing, screening, interpreting, sharing knowledge relating to risk, communicating and interacting with service users, forming judgements about risks and detention, alongside handling or navigating uncertainty and “the inherently moral features of risk” (Brown and Gale, 2018). Epistemic injustice applies to conveying information or knowledge to others, making sense of social experiences (Fricker, 2007), unequal relationships between AMHPs and users and social relations in risk work, the level and nature of involvement in epistemic practices, and the privileged position occupied by AMHPs. Integrating the two theories into a framework could provide a new dimension to the risk literature by illuminating the epistemic practices underpinning the translation of risk knowledge and social relations within the client-facing risk work context.

In the following chapter, I present and discuss the methodology utilised by this study to address the research questions outlined in Chapter 2.

Chapter 4: Methodology

4.1 Introduction

This chapter discusses my methodological approach to data collection and analysis and its epistemological basis. Aiming to provide a detailed account of how this research was designed and conducted, I begin by discussing the ontological and epistemological assumptions, the adopted methodological approach, and alternative considerations. The chapter then outlines the research process, specifying its setting, participants, and access procurement. It also examines the data collection, sampling procedure, and how I analysed data. It then moves to discuss the researcher's positionality and reflexivity, as well as quality assurance. The chapter concludes with an exploration of ethical considerations.

4.2 Ontological and Epistemological Assumptions

The ontological stance or the nature of social reality underpinning this study is social constructionism, whereby reality is not naturally given, but instead comprised of interactions between people that generate social entities (Bryman, 2004). Social constructionists are interested in how the practices and culture of social actors help to create and explain social phenomena or reality; with what is regarded as valid and reliable considered more nuanced than the concepts of objectivity and predictability established in the natural sciences (Patton, 2015).

A social constructionist approach to knowledge is grounded in the idea that the world is socially created through social interactions, understandings, and language (Houston, 2001). Social constructionists focus on the significance of the meaning, interpretation, and interactions between people in the social world, and how they might evolve. Consequently, it emphasises the significance of relationships, and the influence of contingent influences including knowledge, culture, and language on people's interpretations and understandings of what represents or constitutes reality (Carey, 2012).

Social constructionist theory sees meanings as socially created through the collective processes of culture, time, learning, relationships, and the use of power (Gergen, 1985). Through this approach, AMHP decision-making relating to detention can be framed and understood within its cultural and socio-legal context. This considers the existence of multiple interpretations, with researchers and research participants mutually constructing how meanings are given an interpretive understanding within their particular environment (Charmaz and Mitchell, 2001). Examining AMHP detention decisions through social constructionism enabled me to explore the finegrained phenomena and activities of social actors, without dismissing social organisation as a “purely external force” (Silverman, 2000, p.84).

Epistemologically, this research study is situated within an interpretivist paradigm looking to unearth meaning and examining how AMHPs understand their social experiences, interpret the MHA, and construct risk when arriving at a decision (Carey, 2012). This approach locates the researcher within the social world being studied as opposed to separate from it. The researcher and the participants co-produce social reality through the meanings assigned to events or phenomena (Carey, 2012), and thus, an interpretivist views meaning as socially constructed through interactions between people, so that meaning cannot exist independently of the subjective interpretive process (Hesse-Biber, 2017). This diverges from scientific approaches in quantitative research emphasising the acquisition of all-encompassing facts, predictions, and generalisations (Bryman, 2004). This study focuses on the subjective experiences and views of its participants - AMHPs and Black service users - and the wider organisational contexts for detention decisions; capturing the multiple situations, circumstances, or events unfolding during the process, from referral discussions, visits to service users’ homes, or hospitals when forming judgements about whether to detain a person during the assessment.

Researchers following an interpretive methodology see experience, perspective, and people’s accounts as primary sources of knowledge to investigate and gain an understanding of the intersubjective nature of reality (Hesse-Biber, 2017). In doing so, qualitative researchers generate sociological knowledge of people’s interpretations, viewpoints, and understandings of the world around them, rendering an account of people’s everyday interpretations (Carey, 2012).

Qualitative research generates rather than discovers knowledge. Researchers put themselves in social spaces to either gather an understanding of members of a group or to acknowledge their positioning, whereby they can comprehend other people’s lived experiences. Qualitative research cannot be conducted if the researcher is detached from the research context, and so, it requires a researcher to become very much part of the world under study. This cannot be written or presented in the manner of quantitative research which positions the researcher as somehow both distant and an authority in the knowledge production process, due to their objective positioning and application of standardised measurement tools (Hesse-Biber, 2017).

Qualitative researchers employ particular methods when asking questions and offering perspectives on a social world, for understanding a social phenomenon by prioritising subjective and multiple insights. This type of research broadly focuses on words, texts, and images, contrasted with quantitative research focusing on collecting statistical data or numbers to investigate a given hypothesis (Hesse-Biber, 2017).

This current research study seeks to disentangle how AMHPs use their knowledge of the MHA and risk, including their expertise to interpret behaviour or phenomena and form judgements about whether to detain an individual undergoing MHA assessment. It aims to produce knowledge concerned with the interpretations, meanings, experiences, and perspectives of the research participants.

I adopted a qualitative approach because it is an appropriate method for exploring people’s perspectives, interpretations, and the meanings given to their experiences and events (Carey, 2012). Qualitative research seeks to explore the social world from the viewpoint of the person being studied and within their natural environment. This approach to research offers a generous and delicate examination for describing the quality of people’s experiences (Marvasti, 2004), attempting to strengthen the voices of people facing social exclusion, including those of Black and ethnic minority descent (Humphries, 2008). My justification for adopting a qualitative approach stems from the nature and purpose of my research seeking to explore participants' experiences, practices/actions, views, perspectives, meanings, and interpretations of phenomena. Denzin and Lincoln (2018) state that a qualitative approach attempts to answer how social experience is produced and its attached meaning.

4.3 Methodology

4.3.1 Ethnography

My research aims to explore the actual practice of assessing Black people for compulsory hospital admission and the principal details professionals consider when forming their judgements. I utilised an ethnographic design for answering my research questions because this is considered the most effective way of understanding how social workers or AMHPs make decisions relating to detention, enabling me to observe how they truly act in practice rather than through self-reported conduct. An ethnographic approach was chosen to reflect the qualitative, interpretivist research paradigm. We practice ethnography by immersing ourselves in the location where social life occurs and observing how events unfold (Hammersley and Atkinson, 2007; Wedeen, 2010). Central to ethnography is data collection through “participant-observation in a natural setting” (Floersch *et al.*, 2014, p. 5). Ethnography is considered a social practice concerned with the study and representation of culture; allowing for a detailed description of people’s actions and behaviour, it is regarded as an informative technique for distinguishing how things work within a cultural or social setting (Watson, 2011).

Ethnography exemplifies the methodology of a qualitative, interpretivist approach to social research. The aim of conducting research in this tradition is to grasp what it is like to be a member of a social group, what social life means to participants in specific spaces and to understand their lived experiences (Atkinson *et al.*, 2007).

While the primary method of ethnography is participant observation (O'Reilly, 2009, p. 150), it encompasses a broad array of methods, including interviews, "discourse analysis, personal documents, and vignettes" (Brewer, 2012, p. 302). Ethnography is recommended for the exploration of human actions and experiences from the perspective of actors in their 'natural' settings (Atkinson *et al.*, 2001). My ethnographic study involved observing face-to-face encounters between practitioners and service users as they organically occurred (Hammersley and Atkinson, 2007). Observing AMHPs' direct interactions with service users intended to illuminate and advance understandings as to what was articulated and experienced (Ferguson, 2016); allowing certain themes to be emphasised which otherwise would not have been captured (Longhofer and Floersch, 2012).

As opposed to other approaches to qualitative research, a distinctive attribute of ethnography is its repertoire of sources and techniques through which data can be gathered. According to Hammersley and Atkinson (2007, p.3), an ethnographic approach usually involves:

> …the researcher participating overtly or covertly, in people's daily lives for an extended period, watching what happens, listening to what is said, and/or asking questions through formal and informal interviews, collecting documents and artefacts - gathering whatever data are available to throw light on the issues that are emerging from the inquiry.

Ethnographic work is flexible (Amit-Talia, 2000) because fieldwork begins with initial research questions or interests that can be refined throughout the process of the study (Hammersley and Atkinson, 2007). The methodological adaptability of ethnography suits this research because there is little evidence from direct observational studies as to the actual practice of assessing Black people for compulsory admission. Its value means that during fieldwork, the researcher can observe participants' behaviour and actions in their natural setting, and provides the opportunity to ask probing questions clarifying the gap between social work ideals or guiding principles and practice reality. The AMHP's position in conducting MHA assessments and making detention decisions within a fast-paced environment may be highly complex so a researcher's presence observing how events unfold allows them to capture and make sense of these nuances and their complexity.

The methodological value of observing and examining nuanced interactions (Emerson, 2009) and communicative exchanges corresponds with my aim of exploring how AMHPs construct risk concerning Black people when making decisions. Ashencaen Crabtree (2013) demonstrated the importance of ethnographic study for unravelling users' experiences of services such as mental health care, revealing methods to engender positive outcomes for vulnerable individuals, and understanding oppressive and discriminatory practices that may otherwise remain uncovered. As Ferguson (2016, p.156) highlighted, ethnographic fieldwork "can provide even deeper insights into what is done and experienced, as well as what is said in practice". Observing practitioners' everyday, face-to-face encounters with service users allows us to perceive what people do during accepted features of their practice that may otherwise appear ambiguous in narrative accounts (Bisaillon and Rankin, 2012).

While questions have been raised about the ethical implications of involving vulnerable service users in ethnographic research (Abbott, 2017), Ferguson's (2016) study into child protection has shown that a researcher can explore practical social work interactions in intimate places - such as service users' homes - without adversely impacting practice or service users.

Ethnographic fieldwork requires the researcher to get "right up close to real practice encounters" (Ferguson, 2016, p. 156) to identify key influences, patterns of behaviour, context, or external influences, while gaining insight into individual perspectives (Hammersley and Atkinson, 2007). Embedding myself within AMHP teams assisted my observation of interactions and both the formal and informal processes involved in assessing people for involuntary hospital admission. Establishing rapport and relationships over time with my research participants facilitated access to both perceptible and imperceptible events while creating space for exploring thought processes and emotional aspects within their work (O'Connor, 2020). For example, my close relationship with AMHPs enabled them to openly interact with me and freely discuss their cases, their thinking processes, and the gut reactions informing their decisions. However, I deliberately choose to be reflexive, carefully managing my relationships with AMHPs in case our familiarity resulted in researcher over-rapport (Hoolachan, 2019), losing the analytical distance required during qualitative research.

4.3.2 Possible rejected alternative approaches

I considered several methodological approaches while developing my research design. This included conversation analysis, focus groups, and semi-structured interviews, each as a sole method of generating data.

Initially, conversation analysis appeared promising considering the role of language in constructing risk, and its potential to produce a "nuanced understanding of how epistemic injustices play out in practice" (Newbigging and Ridley, 2018, p.43). However, this was discounted because I needed a broader approach incorporating verbal, non-verbal, and observation of face-to-face encounters between professionals and service users to comprehend disparities between practitioner and service user perceptions of risk, or how mental health care is experienced by service users.

The focus group method encompasses several people contributing to an in-depth discussion around a specific issue or a "predetermined topic" (Carey, 2012, p.127). This approach is flexible and offers practical advantages, gathering data from multiple participants concurrently (Creswell and Poth, 2018). However, I rejected this method for being restrictive and unsuitable for extracting the complexities and nuances of AMHP detention decision-making which may have remained concealed within group discourses. Moreover, it appeared inadequate for addressing sensitive issues.

I similarly considered interviews as my sole approach for data collection from participants. However, this was discounted as insufficient for fully exploring my specific interest in AMHPs' detention decisions relating to Black people and their construction of risk during MHA assessments. Besides, interviews used in previous studies relating to AMHP practice (Abbott, 2017; Brammer, 2020) failed to capture or explore the gap between what was said or experienced, and what was done in practice. Using interviews alone limited any data generation producing possible insights into the actual routine practice of AMHPs - one of the objectives of this study - as opposed to the normative perspectives and narratives influenced by the necessity to report expected behaviour.

4.4 Research process

4.4.1 Gaining access

Prior to contacting local authorities and possible research sites to negotiate access, I obtained ethical approval from the University Research Ethics Committee. Further below, I will discuss the process of gaining this, including issues of consent.

I contacted five local authorities in London I had identified as possessing the demographic profile of the service users under research, specifically those from Black backgrounds, establishing contacts with gatekeepers or sponsors within organisations able to support my research and facilitate access to the group, specifically AMHPs. My rationale for choosing inner London boroughs for my research site was that I wanted to conduct ethnographic work in more diverse areas where the disproportionate representation of Black people has been well documented, and where I will be able to capture crucial information. As the targeted population included approved mental health professionals, I also contacted the Chair of the AMHPs Lead Network to discuss my research interests, hoping to solicit his support and gain access to AMHPs, key informants, and gatekeepers. Following a telephone conversation and various email exchanges, the Chair connected me with various AMHP Leads in London and Kent, including the co-chair of the London AMHP Leads Network.

I took advantage of my British Association of Social Workers (BASW) membership to establish networks and relationships with AMHPs. I was invited to attend AMHP forums to explain my study and allow them to ask me questions or air any concerns that they might have regarding my research. Similarly, I shared my research overview with members of the BASW mental health group, receiving considerable interest from various professionals and the Mental Health Social Work Lead - Chief Social Worker Office - who agreed to assist my access.

Through the AMHP network, I liaised with the Associate Director of Mental Health Social Work in one of the local authorities in London regarding access. The senior manager connected me with the local AMHP Lead, inviting me to attend a virtual meeting with her and the AMHPs within the team on the 24th of June 2021. The associate director consequently played a key role in facilitating access to the participants and research site, as well as obtaining research governance approval from the local authority on the 28th of September 2021. Following this, I had a further conversation with the AMHP Lead, with the 27th October 2021 agreed as the start date for fieldwork in Site 1.

An AMHP Lead in another London borough whom I had previously met through the AMHPs forums, invited me to attend their team meeting on the 5th October 2021 to present my research overview and objectives. Following my presentation, most of the AMHPs at the meeting expressed interest in participating in my study. I subsequently shared the information sheets, consent forms, and confidentiality protocol with the AMHPs. The AMHP Lead also played a major role by helping me to acquire research governance approval from the second local authority on the 19th of October 2021. Following further consultation with AMHPs including the AMHP Lead, we agreed on the 3rd of November 2021 as the start date at the research Site 2.

Consistent with the public involvement or co-producing research approach, I liaised with the Public Involvement Lead for NIHR Applied Research Collaboration (ARC), who connected me with the organisation’s public board advisor. I subsequently shared information about my research with this advisor who held lived experience of psychotic episodes and detention, becoming an expert through personal involvement. He offered me advice on both the research design and recruitment of service users as participators. He also advised me to consider offering incentives to potential participants as a sign of appreciation for their time and effort.

In summary, AMHPs were recruited through local authority mental health teams. I liaised with some key informants and senior managers within two local authority mental health teams in London, eager to solicit their support for the recruitment of participants and negotiate access with organisations.

All of my access to observing professional interactions with service users was negotiated through AMHPs, who were asked to seek the consent of service users. During practitioners' meetings, either the practitioner or I explained my involvement to the service user and clearly communicated that if they preferred to be left alone or did not consent to my presence, I would leave. Across all observations, there was only one instance in which a service user declined my presence, and I fully respected their decision. I recruited service users for interviews through mental health service user networks and care coordinators within mental health teams who served as gatekeepers. Newbigging and Ridley (2018) have demonstrated in their research the possibilities for using this approach to sampling. In addition, I involved AMHPs who served as care coordinators to assist in my recruitment of service users accessing support from community mental health services.

4.4.2 Research setting and participants

Research Site 1 contained seven AMHPs and one trainee AMHP in the team, three of whom were permanent workers and five locum workers. This included the team manager, often referred to as the AMHP Lead. All the practitioners at this site were from Black African/Black British backgrounds and totalled six females and two males. Aside from the trainee AMHP, the team's practice experience ranged from one to twelve years (Figure 2).

When the fieldwork began in October 2021, I went to the office two to three times every week, stayed in the team room to observe and sometimes participated in conversations among staff, witnessed discussions about referrals, phone conversations, team meetings, and shadowed professionals undertaking MHA assessments relating to Black service users.

I noted that many important or key moments and events I captured occurred in the office while practitioners engaged in informal conversations - discussing service users or their work - rather than during my observation of actual assessments.

In research Site 2, the team had a mixture of white and Black professionals – four from white British backgrounds, and two from Black groups (Figure 2). There were five females and one male, making practitioners at this site more diverse in terms of race, ethnicity, and gender identity. Generally working remotely, they made visits and undertook face-to-face work when required to complete MHA assessments. They would normally invite me to join their allocation online meetings in the morning, normally lasting approximately 60 minutes, where they would work through their spreadsheet to see which cases needed assessment and who needed to complete what. Working mainly remotely, I was somewhat immersed by attending these meetings and observing interesting conversations and discussions among the practitioners, but I did not feel that same sense of involvement or presence compared to Site 1 which had face-to-face meetings in an office-based environment. Further, most of the participants at Site 2 kept their cameras off during the virtual meetings so it was not possible to see them and observe their body language. However, I did meet six of them in person when observing MHA assessments.

The two sites appeared homogenous in terms of demographic characteries of client groups, social class, deprivation, and detention rates, and as neighbouring boroughs, using the same hospitals, wards, and other related facilities. One of the advantages of conducting my fieldwork over two sites is that it enabled me to gain insights and compare how things worked or were organised in both sites, thereby allowing me greater awareness of certain accepted assumptions.

Figure 2. Profile of AMHP research participants depicting their gender, ethnicity, and number of years practising.

AMHP (Pseudonym)	Number of years practised as ASW / AMHP	Local Authority Mental Health Team	Ethnicity	Gender
Anna	0 - Trainee AMHP	Site 1	Black African	Female
Vivian	1	Site 1	Black African	Female
Venus	5	Site 1	Black African	Female
Yasmin	6	Site 1	Black British	Female
Eve	9	Site 1	Black African	Female
George	10	Site 1	Black African	Male
Kevin	11	Site 1	Black African	Male
Mary	12	Site 1	Black African	Female

Jason	5	Site 2	Black Caribbean	Male
Bridget	8	Site 2	White British	Female
Jane	9	Site 2	White British	Female
Amber	10	Site 2	Black African	Female
Pamela	18	Site 2	White British	Female
Denise	30	Site 2	White British	Female

Regarding the service user group, I interviewed six male service users and one female service user in Site 1. In Site 2, I interviewed one male service user. As the study focused on the role of AMHPs concerning the detention of people from Black communities, I only involved service users from this particular social group.

4.4.3 Purposive Sampling

The current research adopted goal-directed sampling, one of the most effective and commonly used techniques in qualitative research, to select potential participants across two sites (Carey, 2012). This requires a researcher to intentionally select participants deemed relevant to their research objectives or questions and involves an attempt to find a clear link between the research problem and the sampling (Bryman, 2015). The researcher chooses the sample based on their knowledge of the research question (Dawson, 2013).

My research attempts to answer questions about AMHP detention decisions relating to Black people, and how they conceptualise risk to arrive at those decisions. The primary inclusion criteria were adult service users from Black and minority ethnic backgrounds with lived experience of detention under the MHA 1983; similarly, professionals were expected to be AMHPs with direct experience in assessing Black people for involuntary hospital admission. This sampling technique may be limited when “generalising to the population” (Keating and Robertson, 2004, p,441), however, the knowledge and insight gained from this could be transferable in different settings (Morse, 1999).

4.5 Data collection

Reflecting the ethnographic approach, I collected data by combining observations and interviews with practitioners based in two neighbouring London boroughs. To assist my interpretation and to gain an in-depth understanding of practice that could only be obtained through this methodology, I undertook detailed interviews with 14 AMHPs possessing differing levels of experience and training. To fully address the research questions, I conducted semi-structured interviews with a purposive sample of eight service users from Black groups. I triangulated/cross-referenced data from the ethnography and interviews with service users to enable a more detailed and balanced description of what occurs during practice. I explored research questions 1, 2, and 3 by analysing data collected through a combination of observation and participant interviews.

I collected data over six months from October 2021 to April 2022, on average spending two to three days a week with the teams. I observed 15 MHA assessments and interviewed 14 professionals and eight service users across the two site teams, totalling 252 hours of observation. I shadowed AMHPs in all aspects of their work during MHA assessments including both formal and informal processes, such as discussions among practitioners in team rooms, referral meetings, travelling with them to family homes, psychiatric hospitals, section 136 suites (places of safety), and observing their interactions with service users during assessments.

The data includes typed field notes following observations, multiple handwritten notebooks, and transcriptions of audio recordings from interviews with participants.

4.5.1 Observations

I conducted observations of AMHP practice at Site 1 in open-plan spaces in the office, the team duty room, hospitals, service users' homes, and the community. I developed a topic guide (appendix 7) to allow some form of structure in my ethnographic fieldwork which can at times become "messy" (Santori and Jin, 2023).

As Site 1 was my primary research site, I spent a considerable amount of time with the AMHPs in this team, attending the office two to three times every week, staying in the team room to observe and sometimes participating in conversations among staff, observing discussions about referrals, phone conversations, team meetings, and shadowing professionals during MHA assessments involving Black service users. The second team at research Site 2 worked remotely, except during MHA assessments which they completed in person. This meant I had to join their virtual allocation meetings two times weekly, each of which lasted approximately 60 minutes, observing their discussions of various referrals, and the allocation of cases to practitioners. As noted above, even though I observed some significant moments and events at this site, I did not feel the same sense of immersion as in Site 1.

Reflecting a granular method of ethnography (Atkinson, 2015), I paid attention to the details and differing elements within each situation. I recorded descriptive observations of participants' interactions and activities, including speech fragments. I concentrated on the affective dimension, including participants’ body language, the affective atmosphere, sounds, silences, what was being verbalised, how their bodies reacted or moved during conversations, and any evident contradictions. All of my feelings, thoughts, sensory experiences, and interpretations of what was going on were handwritten, following Kenny’s (2008) argument that such experiences are relevant in ethnographic fieldwork.

During my observation of MHA assessments, I recorded field notes of the interactions between the professionals and the service users, alongside discussions among practitioners. I then interviewed or held informal conversations with AMHPs immediately following an assessment about their encounter with the service user, the rationale for their decisions, and their feelings, as well as asking for explanations or clarifying certain things that were either mentioned or avoided during assessments or practice encounters with service users. These together with my thoughts, feelings, and reflections regarding professionals’ face-to-face encounters with service users were handwritten in notebooks. This was done to reflect an ethnographic approach whereby the ethnographer reflexively engages with their position, drawing on the insights offered, as opposed to trying to fully remove the impact or influence of my presence (Shaw and Gould, 2001).

I sometimes went along with AMHPs, often in the same car, as they travelled from the office to the hospital or to the community to conduct MHA assessments. During those journeys, I engaged them in conversation about the referral, the risk knowledge they were drawing on, background information about that particular service user, their plans for the assessment, their expectations, and any other related concerns.

My handwritten observations were recorded in notebooks which were subsequently typed up and saved in Word documents. To avoid falling behind in transcribing my field notes, I always tried to write things down as quickly as possible during and immediately after my observations. As Lareau (1996, p. 217, cited in O'Reilly, 2009) noted, "writing up field notes immediately is one of the sacred obligations of fieldwork".

While observing MHA assessments, I reflected on my position as a social worker - an insider familiar with the professional discourse - and I consciously adopted a less participatory role by merely observing what was going on, including the practitioners' interactions with service users. This was to ensure my non-interference in MHA assessments but also to abstain from engaging in any activity that could easily be interpreted as "doing social work" (Boahen, 2014).

4.5.2 Interviews

To assist interpretation, and gain or develop a comprehensive understanding of practice that could be obtained through observation alone, I undertook detailed interviews with 14 AMHPs, with different levels of experience and training, from both research sites. The interviews provided the space for AMHPs to talk about their cases and engage in reflective conversations with me about their experience of working with service users from Black communities, their views on service user experience, voices, preferences, and level of participation in decision-making, along with their perceptions of service users' knowledge and circumstances. Through interviews, I also explored the practitioners' demographic information, professional identities, job roles, professional qualifications, length of time and experience both as an AMHP and in social care generally. This provided another layer of understanding and insight into the AMHP conceptualisations of risk, their perspectives, and accounts of Black service users' circumstances, the organisational context, and the specific challenges they encountered when discharging their role. As an iterative process, field interviews offered space to explore with the AMHPs the significant events and themes that had emerged within the observational component of my ethnographic work. Most interviews lasted between 60 and 90 minutes, with the AMHPs valuing the opportunity to reflect on their practice, and how they experienced risk work through the feedback they provided following the interviews.

I conducted semi-structured interviews with a purposive sample of eight service users from Black groups, exploring their perspectives on their detention experiences, and community services. As mentioned previously, I recruited service users for interviews through mental health service user networks and care coordinators within mental health teams serving as gatekeepers to users. I initially planned to interview more service users, but only a few of those who were approached by the gatekeepers expressed any interest and gave informed consent to participate in the research. My interviews with service users from Black communities helped my analysis of how they experience AMHP detention decisions and mental health care.

4.6 Data Analysis

The analysis of data within this ethnography is not bound to a specific section of this study (Hammersley and Atkinson, 2007) but rather is an ongoing feature of the research. My approach to data analysis was informed by qualitative ethnographic principles establishing it as a recursive and inductive process beginning at the first interview and continuing through to the process of writing up findings (Bisaillon and Rankin, 2012). My analytic process was formed through recording field notes, constant reflection, thoughtful engagement with the data generated, and the process of reflexivity.

I transcribed interviews verbatim and assembled them with typed field notes from my observations, before importing the data into NVivo to assist with organising and coding. I utilised Braun and Clarke's (2006) six-phased thematic analysis to facilitate an open, recursive, and exploratory engagement with the data. The first phase of this thematic analysis was to establish familiarity and a deeper engagement with the data through listening and re-listening to audio recordings of the interviews, transcribing these, reading and re-reading the textual data including the typed field notes, and recording ideas. I gradually moved through the whole dataset, logging notes in the transcript margins using Microsoft Word's comment function. While actively engaging with the data, I was identifying patterns and asking questions about it including participants' perspectives, the relevance of their responses to my research questions, and any assumptions made.

Having familiarised myself with the entire dataset, I progressed to phase two, creating or generating initial codes combining a manual process and the NVivo programme. This aspect of my analysis involved identifying relevant data within each dataset and labelling these with a phrase or a few words that encapsulated my interpretation or meaning of the data concerning my research questions. I also engaged in constant comparison across data items, noticing interesting accounts and cases, including those that were unsuitable or conflicted with my initial analysis. This was consistent with Silverman's (2011) guidance for treating data comprehensively; engaging with the entire dataset so as not to focus on aspects of the data that initially fitted with the preliminary thematic categories and codes.

Following Braun and Clarke's approach (2006), I generated multiple codes of all data items, producing a codebook in NVivo with a compiled list of codes and associated descriptions identifying patterns, but also, the heterogeneity of relevant interpretations and meanings across the dataset. I then used NVivo to organise and gather the data segments relevant to each code before proceeding to theme generation.

In phase three of the analysis, I built upon my earlier engagement and understanding of the data through familiarisation and coding to frame the initial thematic categories. This entailed categorising the different codes into potential subjects and collating all the data pertaining to each, using my research questions and theoretical framework to identify the relevant data segments and connected stories. Consistent with Braun and Clarke's (2006) approach, I constructed themes by rigorously examining the codes - and the relevant data - collating and merging them into "more meaningful patterns" (Terry *et al.*, 2017, p.12). I followed Braun *et al.*'s (2015, p. 102) suggestion to establish a "central organising concept" underpinning a theme to help me decide what specific subjects were represented and if their associated label or data extract reflected this.

Having collated the codes and created potential themes, I advanced to phase four to further refine them. This involved evaluating whether the potential themes matched the tagged data segments, considering the meaning of coded extracts while using NVivo to create thematic maps of the analysis. I also checked whether the themes I had created meaningfully encapsulated the dataset (Braun and Clarke, 2006), with some requiring further adjustment or outright rejection.

Whilst this refining process continued, I began naming and defining my themes for phase five. This involved describing and clarifying particular individual themes and writing clear and brief definitions for each, alongside the analysis necessary for comprehending the narrative or its interpretive story (Braun and Clarke, 2006). This process of defining themes enabled me to decide whether I possessed adequate detail for a core chapter or whether it might better fit as a sub-theme in the “analytic story” (Terry *et al.*, 2017, p. 15).

I discussed coding, initial development, and refining and defining the themes with my supervisory team. These discussions and feedback from the team enhanced my “inter-rater reliability” (Newbigging and Ridley, 2018, p.39) and arguably improved the credibility of this qualitative research process.

Throughout this thematic analysis, I thoughtfully and reflexively engaged with the data and the analytic process, recognising my subjectivity and positionality in the research process. During coding and the construction of themes, I continually engaged in critical reflection by questioning my interpretations and the underlying assumptions I was trusting when coding and generating my themes (Braun and Clark, 2019). I operated from a position that themes do not just emerge but are understood as something produced by the researcher at the “intersection of the data, their theoretical and conceptual frameworks, disciplinary knowledge, and research skills and experience” (Terry *et al.*, 2017, p. 5). Repeatedly engaging with and fully immersing in the data was critical for ensuring credibility during this approach to data analysis.

The final stage of this process, phase six, involved producing the report; including the selection of compelling data extracts, a final analysis of these, linking my analysis to the research questions and the relevant literature, producing a “scholarly report of the analysis” (Braun and Clarke, 2006, p. 35). At the point of composing the final report and presenting the themes in the chapters detailing my findings, I had already completed a substantial amount of writing since the beginning of my fieldwork.

It is worth noting that my analysis was not completed sequentially or following a linear manner whereby I simply progressed from one phase to the other, but rather I followed an iterative process, repositioning as required throughout the stages (Braun and Clarke, 2006).

4.7 Researcher positionality and reflexivity

The qualitative approach locates the researcher within the social world they are studying rather than separate from it (Carey, 2012). As qualitative researchers, we have an ethical responsibility to recognise the potential influence of our identities, and our positionality in the decisions we make when gathering and analysing data or transcribing findings. Consequently, we bring our own values, experiences, emotions, beliefs, and personal preferences to all aspects of the research process (Willig, 2001). Accordingly, it was crucially important that I was reflexive and critically aware of how this might influence my research.

Reflexivity is described as a self-evaluation of how a researcher’s position impacts the research process, beginning with the design, the utilised data collection methods and analysis, and the delineation of the social world (Basit, 2013). This is perceived as a process of ongoing internal dialogue and self-monitoring of the researcher’s positionality, and the subsequent awareness of how this could influence the research (Berger, 2015).

Reflexivity is vitally important for understanding and reconciling a researcher's positionality, identities, and unintentional biases that may potentially shape their research (Braun & Clarke, 2013). As Holmes (2020) noted, researcher positionality is fluid and can transform during the project, so I engaged in ongoing critical reflection and self-evaluation regarding my role as a researcher, the influence of my identity on the study, the context, and its respondents.

Considering the nature of my research, I consistently reflected on the insider and outsider roles of the ethnographer. To a certain degree, I saw myself as embedded by virtue of my role as a social worker, possessing practice experience and knowledge of the MHA; recognising the demanding responsibility to balance care and control; accepting that as a last result, some individuals in specific circumstances will require involuntarily hospital admission for their treatment and care; but also acknowledging the potential iatrogenic harm resulting from detention. The research site was a familiar environment for me, requiring much critical reflection on my part as to whether my professional identity might influence my choice of questions, what to observe and how to interact with other social workers, and my reading of a participant's interpretations and perspectives. I felt that my professional identity as a social worker helped me to establish rapport and close relationships with other social work AMHPs, permitting them to openly talk about their cases and assessments and to interact with medical professionals. I believe this created an opportunity for me to obtain considerably detailed descriptions and rich data; however, I recognised the challenges presented by my immersion in our shared field of practice/social space concerning how I easily inferred meaning to silences or those things both said and unsaid during my interaction with the participants. I acknowledged my role as a practitioner observing fellow practitioners for a study, requiring reflexivity, mindfulness, and the diligent application of my skills to my research role.

I also acknowledge that my identity as a Black man conducting a study concerning people from Black and minority ethnic communities might influence my fieldwork. For example, during interviews, some of the Black professionals and Black male service users identified with me, referencing me during their responses. I felt my ethnic background helped me to build rapport, creating empathy as to the emotional content and lived experiences of my participants; however, my closeness to the study's subject matter required critical awareness as to the impact of my assumptions, beliefs, judgements, and social location within the research process. As Braun and Clarke (2013) noted, reflexivity is especially vital for researchers possessing an identity relevant to the research topic.

I recognised I needed careful reflection and thoughtful engagement with the research process, including the data collection and analysis, explicating my positionality and advancing my contextual understanding to safeguard the credibility of my research and its outcome (Finlay & Gough, 2008). Continual reflection and reflexivity regarding my position, beliefs, preconceived ideas, and biases relating to the subject matter were crucial in all aspects of the research process (Savin-Baden, 2004). I kept a reflective journal (Braun and Clarke, 2013) throughout my fieldwork noting my decision-making, the development of my notes, and the affective dimension - including my emotional responses. I utilised my academic supervision as a space to reflect on my feelings and how my identity, practice experience, and values potentially influenced my data collection and analysis.

Recognising the interplay between my professional role as a social worker, my responsibilities as a researcher, and my identity as a Black man, I remained critically aware of how these intersecting positionalities could shape the research process. I made a concerted effort to apply my research methods with rigour, aiming to mitigate the impact of any preconceived ideas or theoretical commitments - particularly those related to epistemic injustice and risk work - on participants' accounts and experiences. Throughout the study, I prioritised methodological reflexivity, actively privileging my skills in social research over personal assumptions and experiential knowledge. I engaged in continuous self-reflection to examine my own beliefs and biases. During data collection, I employed open-ended questions many of which emerged organically from the ethnographic observations, enabling participants to articulate their perspectives in their own terms and reducing the imposition of external narratives.

Reflexivity requires an evaluation of data from diverse perspectives. I was critically aware that my analysis and interpretation of observation and interview data would be entangled with my subjective experiences (O'Connor, 2019), and therefore, ensured I presented examples of my initial analysis and interpretations in my supervision meetings to explore or discuss alternative meanings and understandings.

4.8 Quality Assessment

Academic excellence and credibility are pertinent within all research studies and so, I took steps to ensure quality assurance during my research using Lincoln and Guba's

(1985) conceptualisations of credibility, transferability, dependability, and confirmability.

Credibility is defined by the extent to which research outcomes or findings are considered accurate, reliable, and legitimate. To establish this, I used a range of strategies including prolonged engagement, persistent observation, triangulation, (Lincoln and Guba, 1985) and the reflexivity previously discussed. Extended or prolonged engagement requires a researcher to spend sufficient time at research sites or settings to understand the culture being studied. Selecting an ethnographic research approach, I spent over six months at the research sites closely observing AMHP practice, establishing rapport, and gaining an in-depth understanding of both practitioner decision-making and the organisational culture.

Persistent observation requires the researcher's attentiveness to participant emotions and the studied situation to provide meaningful and abundant data (Lincoln and Guba, 1985). I spent considerable time observing the AMHPs' everyday practice, their face-to-face encounters with service users, their interactions with other professionals including their managers and medical professionals, their working environment, and the primary influences shaping their decision-making. This allowed for detailed descriptions of my participants' actual behaviours (Geertz, 1973).

Similarly, I attempted to ensure credibility through data triangulation, collecting from multiple sources and using different methods, including observations from two research sites possessing different teams, and interviewing both AMHPs and service users. I accumulated data from these observations and interviews to provide rich accounts of AMHP practice and service user perspectives of their detention experiences.

As the fieldwork and my data analysis progressed, regular supervision proved crucial to ensuring credibility (Nowell *et al.*, 2017). As previously outlined, I discussed the analytic process with my supervisors including coding, initial theme development, and refining and defining these. The feedback from my supervisory team facilitated "inter-rater reliability" (Newbigging and Ridley, 2018, p. 39). Peer scrutiny through peer mentoring, my continuation presentation at the university, discussions and feedback from various academics, and presenting my initial findings at conferences such as the Joint Social Work Education Conference (JSWEC) allowed for the critical interrogation of my data analysis and conceptual framework, helping me to evaluate the data from differing perspectives while refining my initial themes.

Transferability was my second measure for assessing the quality of my research, relating to how my findings might be demonstrably applicable in other contexts (Guba and Lincoln 1985). In comparison to quantitative methods, qualitative research has been criticised for its subjectivity and insufficient generalisability, (Koch & Harrington, 1998). However, if there is transparency, sufficiently detailed information about the participants and research context, and the findings are understandable to outsiders, the research meets the requirements for transferability (Cope, 2014). This was achieved in this study by using both observation and interview data to provide thick descriptions and detailed information about the research.

Dependability became my third indicator of quality, demonstrated through data consistency and replicable findings (Guba and Lincoln 1985). To ensure this, I maintained an audit trail of records including observation field notes, interview transcripts, reflective notes, research information sheets, consent forms, interview guides, supervision meetings, and data analysis records.

My final measure of quality was confirmability, referring to the researcher’s ability to demonstrate that their data represents participant accounts rather than research bias. To ensure this, I provide a clear description of how I constructed interpretations and conclusions (Cope, 2014), supported by detailed information about participants’ perspectives and direct quotations from the data. I further monitored the confirmability of my research findings through the audit trail and reflexivity previously discussed.

4.9 Ethical Considerations

Ethical approval for the research was granted by the University Research Ethics Committee. I also obtained research governance approvals at each study site from the necessary local authority. I only included service users and AMHPs obtaining written consent and gave as much information as was requested to inform their choices regarding participation. I facilitated this by writing a clear Participant Information Sheet (see Appendices 1 and 2) which I explained verbally, assuring them of my availability to answer any of their questions, to ensure that potential participants were fully informed prior to their involvement. Participant consent was grounded in an awareness that it could be withdrawn - and they could exit the research - at any time without suffering any consequences. Participants were assured of confidentiality and the voluntary nature of their involvement, but also advised that the disclosure of any information suggesting someone was at immediate risk of serious harm would need to be reported to the appropriate authority.

With service users, I forwarded written information about my research to mental health service user-led groups, while asking AMHPs and care coordinators to introduce the research to their clients and give them a flyer. Participants interested in the study were able to contact both professionals and the researcher and once introduced, I spoke directly with each individual, furnishing them with detailed information about the research by going through the participant information sheet with them, to ensure their full understanding prior to obtaining their consent. I did not involve any participants who appeared unable to give informed consent, meaning that service users lacking this were excluded from the study. A service user's capacity to consent was determined by care coordinators and AMHPs serving this role.

As previously mentioned, all access to observing interactions between professionals and service users was negotiated through AMHPs who were asked to seek their client's approval. During meetings with service users, they received an explanation as to my involvement from me or the practitioner, respecting any indication suggesting they wanted to be left alone or did not consent to my presence.

The accumulated data was anonymised to ensure participants could not be identified, including their names, results, and findings. Any potentially identifying characteristics were either removed or changed to maintain confidentiality. I separated personal information from the data, assigning participants pseudonyms and numeric identifiers for the final report, and tracking each case so that the data generated through my observations and interactions with professionals could be cross-referenced with the service user interviews. This also meant that I, the researcher, was the only person holding information as to the true identity of the participants. The collected data were kept private and secured using an encrypted, password-protected file. This was deposited on the University network system, with backup versions stored securely on an encrypted external drive. Once saved, the original audio was deleted from the recorder to minimise any potential risk when transferring the material. All sensitive data was held in an electronic format apart from signed consent forms which were held securely in a locked filing cabinet. I used the collected audio solely for this research, which was destroyed upon completion of the study, and ensured that audio transcripts restricted any information that could be linked to participants.

Being mindful that people might find the enormity of detention difficult to discuss, I was aware of the possibility that participants might experience emotional distress when discussing past lived experiences. During my observation of practices or when interviewing, whenever it became clear that a participant was struggling to discuss their experiences, I would pause the interview and check whether they wished to continue. I assured them that the content of their disclosures was entirely self-determined and that there was no pressure whatsoever to discuss anything that felt uncomfortable. Participants were given an opportunity at the end of the interview to discuss any concerns with me.

Additionally, as the research process could generate unexpected ethical issues, I undertook a constant assessment of risk. Doing so ensured that the research was effectively conducted by mitigating and minimising any potential risk to all involved.

Service user participants were given a £10 voucher upon completion of an interview, to show appreciation and acknowledge their time and efforts. Payment - in the form of vouchers - can facilitate involvement or engagement with research particularly by marginalised groups, but also conveys respect and appreciation for their time (Solanki, 2020; Bonevski *et al.*, 2014). However, I acknowledge that financial encouragement may unduly influence participation and for this reason, I ensured that the offered amount was appropriately valued to provide adequate compensation for their time without being coercive.

4.10 Conclusion

This chapter has provided a detailed discussion of the qualitative methodology I used during this study. I began by exploring the ontological and epistemological assumptions underpinning the research, alongside the rejected alternative options and considerations. Subsequently, this chapter outlined my research process including how I secured access to the research sites, the nature of the research setting, and the participants involved in the study. The chapter then discussed the methods I employed for data collection including participant observation and field interviews, alongside my data analysis process. This was followed by a discussion of researcher positionality and my reflexive considerations, before concluding with a detailed exploration of the ethical principles informing this research. The following two chapters will present the thematic analysis and findings of this thesis.

Chapter 5: The role of risk and ethnicity in decision-making about detention

5.1 Introduction

This chapter addresses the research questions: *How do AMHPS make decisions relating to detention and what influences their judgements? How do practitioners think about and construct risk when arriving at a decision?* And *what are service users' perspectives on their experience of detention and community services?* Building on the discussion in Chapter 2 concerning the formal role of the Approved Mental Health Professional (AMHP), this chapter opens with an overview of the AMHPs' working environment and 'a pen sketch' of their daily practice. This contextual foundation supports a more nuanced exploration of the decision-making processes, as revealed through the study's data. My process of thematically analysing fieldnotes and interview data resulted in the identification of major overarching themes and sub-themes, which will be used to structure the presentation of the research findings. This chapter is divided into five main themes/sections, namely: the influence of risk on detention decisions; managing risk in the community; racialised risk assessments; tensions arising in MHA assessments; and the myth of autonomy. The chapter discusses how AMHP decisions about detaining Black people are often shaped by a professional's understanding of risk factors concerning the assessed individual - especially risk presented to others. There is evidence of a close relationship between the legal criteria for involuntary hospital admission and the classification of risk, which is often influenced or shaped by a service user's race or ethnicity. I review the tensions arising from translating and managing risk during the MHA assessment process and the problematic ways in which AMHPs experience risk work while highlighting Black service users' experiences of AMHP decision-making. Within this chapter, I also discuss managerial culture and protocol-driven forms of practice, finishing with the challenges that AMHPs face when bringing social perspectives into their decisions alongside the dominant legal/biomedical model, multiagency working, organisational factors, resource implications, and 'blame culture'. This chapter demonstrates that despite the obligation for AMHPs to utilise the social model in practice and recognise and challenge behaviours or aspects of the law that discriminate against particular social groups or people from Black backgrounds who experience disadvantages and poorer outcomes within the mental health system, decisions made relating to detention are very much shaped by professionals' preoccupations with risk - to other/public - and the racial discrimination embedded in MHA assessments.

5.2 AMHPs and their work environment

This section situates the working environment of AMHPs within its broader organisational context, emphasising the complex conditions under which they make decisions. It highlights the resource-constrained nature of their practice, shaped by bureaucratic pressures, defensive strategies, and the pervasive influence of blame attribution. By establishing this contextual foundation, the section enables a more nuanced interpretation of the AMHPs' decision-making processes explored through the study's data, thereby enriching the discussion presented in Chapter 7.

A day in the life of an AMHP is varied, demanding, and full of challenges that call for a combination of knowledge of the law, emotional resilience, decision-making skills and problem-solving capacities. AMHPs are trained professionals who are legally mandated to make decisions about detention of people suffering from mental disorders under the MHA 1983 (Brown, 2016).

An AMHP is a registered professional who has completed further training approved by the local authority and regulated by Social Work England - in order to perform statutory duties under the MHA (Karban et al., 2020). Eligible professionals undertake the AMHP role on behalf of a Local Social Services Authority (LSSA), who is legally responsible for the AMHP service. The role is also closely connected to NHS Mental Health Trusts, who provide many of the services that AMHPs require to discharge their duties (DHSC, 2019a). Traditionally, social workers solely held this role, which was previously called the Approved Social Worker before the 2007 amendments. Since 2007, mental health and learning disabilities nurses, occupational therapists, and chartered psychologists have been eligible to train as AMHPs. However, social workers still make up 95% of those in the AMHP position (Carson, 2018).

AMHPs are responsible for setting up, coordinating and completing assessments under the MHA and, if required, making applications to detain people in hospital for assessment and treatment of their mental ill-health (DHSC, 2021). A typical day of an AMHP also involves liaising with two medical doctors, arranging for MHA assessment to be undertaken, identifying the Nearest Relative (NR) and organising key agencies, such as police and ambulance. If the outcome of the assessment is involuntary or voluntary admission to hospital, the AMHP must obtain a hospital bed, arrange for an ambulance to convey or transport the assessed person and accompany them to the hospital (Stevens et al., 2018). According to the National Workforce Plan for AMHPs (DHSC, 2019b), “AMHPs are independently responsible for a decision to detain a person and arrange conveyance to hospital” (pg. 5). AMHPs also have a central responsibility of ensuring that service users’ human rights are maintained and that the guiding principles of the MHA, as stipulated in its Code of Practice (2015), are complied with (DHSC, 2019b).

As stated above, local authorities have a legal responsibility to run and manage AMHP duties, train and support AMHPs, ensure competency, provide indemnity and legal advice in relation to AMHPs’ duties (DoH and CQC, 2016: 6).

5.2.1 How are the AMHPs Evaluated?

AMHPs are evaluated through a mixture of training requirements, service standards, and performance indicators or assessments.

Firstly, AMHPs must follow national service standards, which clearly set out the expectations for their role and responsibilities. These standards are formulated with input from local authorities, Social Work England and Department of Health and Social Care (DHSC, 2019a).

Secondly, AMHPs are required to complete 18 hours of training each year to maintain their mandate to act as an AMHP for a local authority. This training is designed to ensure practitioners keep up-to-date with practice standards, current regulations, and new developments in mental health care. Local authorities are responsible for assessing the performance of AMHPs. This involves regular appraisals, supervision, managerial oversight, and feedback from both colleagues and service users. AMHPs are therefore subject to continuous monitoring to ensure they maintain professional standards. This includes annual performance reviews, formal reapproval processes, and monitoring submissions. The overarching aim is to ensure that AMHPs deliver high-quality assessments and support for individuals experiencing severe mental health difficulties (DHSC, 2019b).

5.2.2 Pressure on AMHPs

AMHPs face huge challenges and pressure in discharging their role. This pressure partly originates from organisational factors - such as data monitoring and practitioner liability for risk management failures. They also face pressure from various sources including, a high caseload for AMHPs resulting from rising number of MHA assessments, and a decline in the number of AMHPs - with recruitment and retention problems compounding the situation (Community Care, 2018). Furthermore, a lack of resources such as shortage of hospital beds and appropriate community services means that AMHPs grapple with finding appropriate care and support for people experiencing mental health crisis (Mithran, 2024).

There is a pressure on AMHPs to follow bureaucratic processes including demand to complete extensive paperwork, within a limited timeframe. Failure to comply with these bureaucratic protocols and other risk management practices often results in AMHPs losing their jobs. The pressures within the AMHP service can imply that persons experiencing mental health crisis do not always receive the quality of service they should expect (DHSC, 2018). These pressures also have an adverse impact on workers morale, recruitment and retention (DHSC, 2019b).

Risk management practices such as case audits, which are used to assess and hold AMHPs accountable, are seen as influential in shaping how they carry out their roles. The literature highlights that practitioners' anxiety regarding accountability for negative outcomes, compounded by public scrutiny and a pervasive "blame culture," significantly impacts their daily practices (Quirk et al., 2003). Douglas (1990) further elaborates that this dynamic represents the "forensic function" of risk, a process focused on determining who is responsible when negative events occur.

From this, it is evident that AMHPs work within a framework shaped by organisational constraints, a dominant blame culture, limited resources, and the lack of viable alternatives to compulsory hospitalisation. These interconnected factors create substantial pressure on practitioners.

The AMHPs are most accountable to their line managers and their employer - the local authority who is responsible for recruiting, evaluating the AMHPs’ performance and annual reapproval processes. Although the AMHP has a personal responsibility to make a decision on whether to make an application for detention, the AMHP is still accountable to the local authority who decides whether they are currently competent to practice (Brown, 2016).

5.2.3 A pen sketch informed by my professional experience and scholarly literature

A pen sketch portraying a typical day in the life of an AMHP illustrates the practical and emotional challenges they face in their role (Keown et al., 2018). An AMHP's day often begins with a team meeting to review cases they need to assess or manage. These cases are frequently referred by other professionals and agencies such as the police, GPs, hospital staff, or care coordinators.

In the morning

The morning usually starts with a thorough review of cases. AMHPs read through referrals and examine the individual’s mental health history, previous assessments, known risk factors, and relevant medical information. This process is crucial in forming an initial understanding of the individual’s needs and the urgency of the situation (Crawford, Brown and Boardman, 2019). Collaboration plays a central role in the morning routine, requiring AMHPs to liaise with psychiatrists, nurses, care coordinators, and occasionally police officers to compile a comprehensive picture of each case (Townsend, Cutter and Rose, 2020). Alongside this, the AMHP organises their schedule - arranging meetings with service users, identifying a Section 12-approved doctor, and liaising with relatives.

Early afternoon: assessments and support

As the day progresses into early afternoon, the core responsibilities of the AMHP come to the fore. They conduct assessments in a variety of settings - these may include hospitals, community centres, private residences, or police stations. Here, the AMHP engages with service users to assess their mental health and determine whether they meet the legal criteria for involuntary detention under the MHA (DHSC, 2015).

These assessments often require AMHPs to meet with other professionals - psychiatrists, psychologists, nurses, social workers, and care coordinators - to discuss case details and share risk assessments, ensuring that decisions are well-informed and collaborative (Nathan, Bogg and Lewis, 2021). In some situations, the AMHP may be required to manage crises, acting swiftly to determine whether immediate detention is necessary to protect the individual or others.

However, assessments under the MHA are rarely straightforward. AMHPs must frequently navigate the complexities of risk management, especially when dealing with individuals who have a history of unpredictable behaviour or self-harm. From the moment a referral is accepted, the AMHP holds responsibility for the risk until the person is admitted to hospital - an immense pressure that demands both speed and accuracy in judgment (Crawford, Brown and Boardman, 2019). This is compounded by the need to navigate complex family dynamics and resistance to intervention (Allen, 2014), while respecting individual autonomy.

Late afternoon: documentation and conveyance

By late afternoon, AMHPs often turn their attention to documenting the day’s work. Every decision, particularly those involving compulsory admission, must be clearly and accurately recorded. This paperwork is vital not only for legal compliance but also for managing risk and ensuring accountability (DHSC, 2015). If an individual is to be detained, the AMHP must secure a hospital bed, arrange ambulance transport, and may be required to accompany the person to hospital (Keown et al., 2018). They must also complete a formal report summarising the MHA (DHSC, 2015), an administrative task that is crucial but time-consuming.

The evening and emotional toll

Although the formal workday may end, many AMHPs are on-call and can be contacted at any time with urgent referrals. As they leave the office, they often feel both physically tired and emotionally drained - yet quietly fulfilled in knowing that their efforts have provided vital support to vulnerable individuals.

The emotional burden of their work is significant - frequently involving exposure to trauma, distress, and life-altering decisions. The role is emotionally demanding, as AMHPs frequently encounter distressing situations, working with individuals in crisis or enduring severe emotional distress, which can take a significant psychological toll (Nathan, Bogg, & Lewis, 2021). A constant sense of “unfinished business” also prevails - the awareness that another complex case or difficult decision is always just around the corner (Townsend, Cutter, & Rose, 2020).

Ongoing issues and systemic challenges

The broader context of the AMHP role includes several ongoing challenges. Decision-making often occurs in demanding environments, where AMHPs must make critical judgments under time pressure and emotional strain. Compounding this is a shortage of AMHPs in England, which results in large caseloads that can hinder the ability to deliver thorough and compassionate care (Stevens, Howarth and Swindells, 2018).

The complexity of mental health conditions further complicates assessments, as many individuals do not meet clear-cut criteria for detention. This demands in-depth knowledge of varying risk factors and mental states, alongside the capacity to make ethically sound decisions (Dawson and Szmukler, 2006). Balancing individual rights and public safety remains a constant source of tension, particularly in situations where individuals are resistant to intervention (Chiswick, 2012).

In addition, AMHPs must contend with stigma and criticism. Detaining someone under the MHA can lead to perceptions of coercion or hostility from service users or families, despite the AMHP's intent to act in the individual's best interest (Allen, 2014). Organisational constraints, a prevailing blame culture, limited resources, and the lack of alternatives to detention add further strain, leaving many practitioners feeling overburdened and unsupported (Nathan, Bogg and Lewis, 2021).

Conclusion of the day

As the AMHP returns home, they carry the emotional burden of the decisions made throughout the day and their consequences. AMHPs regularly encounter not just the logistical or practical challenges of assessments and paperwork, but also the emotional toll of supporting individuals who may be feeling isolated or distressed. The role demands a strong sense of empathy, resilience, and the skill to manage legal and ethical challenges, while safeguarding the rights and dignity of individuals they assess (Keown et al., 2018).

5.3 The influence of risk on detention decisions

This section focuses on AMHPs' general approach to decision-making about compulsory detention and the specific factors considered when forming judgements. This theme relates to how AMHPs use their knowledge of risk in the context of the MHA's legal criteria to identify the influences considered relevant to their decision-making. While this is well established in the literature, risk remains central to AMHP responses, impacting both their judgement and service users' experiences of detention. Consequently, risk has dominated outcomes for many years and remains prominent in the findings of this current study. My analysis of the data shows that AMHPs construct cases by considering the nature of the risk pertaining to the individual subject to assessment, alongside other clinical risk indicators including a person's vulnerability, their understanding of their mental illness, medication compliance, and history of 'risky' behaviours. It is worth noting that while AMHP descriptions of the role risk occupies in the decision-making process appear universal and applicable to all service users, race and ethnicity were pivotal in its classification and conceptualisation – with professionals' risk thinking over Black service users often shaped by public safety agenda or risk to the public. This will be discussed further in section 5.5.

When asked about decisions over making an application for detention, risk featured prominently in the interviews with AMHPs. The risk that service users present to themselves or others is central in AMHPs' decisions about whether to make an application for detention. This reflects the implicit risk criteria of the MHA 1983, rendering detention necessary for protecting the health or safety of the person or others (DoH, 2015). Whilst the term ‘risk’ was not directly referenced in the MHA as grounds for making a detention application, the associated Code of Practice 2015 (14.9) explicitly requires evidence of risk for deciding whether a person should be detained for their safety or health and also highlights consideration of the “nature of risk” to others resulting from a patient’s mental disorder when deciding whether detention is necessary (CoP 14.10). Accordingly, risk remains the “major organising paradigm” (Warner *et al.*, 2017, p.1) in MHA assessments, and the participants in this research drew on this criteria when arriving at their detention decisions. During my conversation with George – a Black male AMHP with ten years of experience - regarding the relevant influences or circumstances that led to his decision to detain a service user, he referenced a patient’s suicidal thoughts and the risks arising from his condition as key factors in his decision to make an application for detention:

> Well, he said to Mum basically that he was having this persistent thought asking him to go out… to go and jump off the window, and on one occasion… erm, Mum managed to persuade him not to act on those suicidal thoughts. He wanted to go and jump off the window with intent to kill himself… erm, because of his OCD he usually copes with those thoughts, you know, by making his bed several times, taking the sheet out, putting it back on. But I think it got worse, so his Mum called Quora. (George, a Black male AMHP of ten years, Site 1)

Whilst this AMHP conceptualised the risk factors according to the symptoms of a person’s mental illness and the risk to the individual, the family dimension - which will be discussed in more detail in the next section - appeared to influence his decision. The service user’s mother was seen as a protective factor, having made the referral for the MHA assessment and providing the basis for the AMHP to recognise the risk as high and therefore warranting hospital admission.

There is evidence that AMHPs' decision-making relating to detention often extends to safeguarding matters, such as the financial abuse of individuals with declining mental health conditions. An individual’s susceptibility to exploitation from others is often conflated with risk to self when considering involuntary admission, as Jane (a white female AMHP of nine years, Site 2) explained:

> Well, the circumstances were that she was deteriorating. She was disinhibited. She was putting herself at risk and, you know, when that happens, she starts meeting other people who definitely test her vulnerability in terms of finances and things like that.

It is evident from the above quotation that the AMHP identified “disinhibition” as a risk factor, with financial abuse as just one possible harm arising from it. The focus on the service user’s lack of self-restraint or control became an aspect of their behaviour that might render them “vulnerable” or at risk of harm from others. The AMHP seemed to construct this case by deploying her knowledge of risk alongside her perception of vulnerability, with the service user being positioned as a passive recipient lacking agency and requiring intervention from professionals (Williams and Keating, 2000). This reinforced or strengthened the power of a professional during decision-making, with an individual’s vulnerable status as an implicit “moral justification for stronger social control mechanisms” (Brown, 2012, p. 46), such as detention.

The AMHPs also considered detention if a person was showing signs of “relapse” and presenting a potential risk to themself. This risk was closely linked with a person having a mental disorder and requiring hospital admission, and the implicit identification of a causative relationship, for example, when a person’s mental illness functioned or manifested through their presentation or behaviour (Brammer, 2020):

> First of all, he needed to be in hospital. Yeah, he was unwell, and all the relapse indicators show - the relapse signs indicated that he was heading towards admission. So, he had a mental disorder, there were risks to himself by sitting

> in the park in cold. He wasn't appropriately dressed and he was really, really cold… He hadn't been taking his medication. So, there was a risk to his health, and a risk to others not so much because he wasn't a violent person. (Kevin, a Black male AMHP with eleven years of experience, Site 1)

The AMHP constructed risk through the features observed in the service user's presentation or behaviour, such as non-compliance with medication and self-neglect. In the above extract, Kevin arrived at his decision to detain the person by constructing the risk as being related to "his health" rather than as a danger to the public.

In circumstances where a service user did not recognise that they had a mental illness requiring them to take medication, the AMHPs describe them as lacking the understanding or knowledge as to their mental disorder and the subsequent risk. Practitioners similarly rated the risk as high if the person was likely to refuse medication while in the community:

> Do they understand that they need medication? So, if he didn't have understanding that he is mentally unwell, he is taking a medication but he doesn't have an understanding of why he's taking the medication. So, because of that the risk of him stopping medication or refusing medication are high, because he doesn't know that he's unwell. He doesn't know that he needs medication. So, the risks are high, so he has no understanding. (Venus, a Black female AMHP with five years of experience, Site 1)

The above extract indicates that even when a service user undergoing an MHA assessment complies with their medication but rejects the professionals' perspective that their behaviour is a symptom of mental illness, they will continue to construct the risk as 'high'. This constitutes a form of epistemic injustice, as the service user's perspective on what may have triggered their behaviour is deemed irrelevant to the AMHP's decision-making, insofar as it does not align with the professionals' interpretation of risk. AMHPs' emphasis on diagnosis and risk assessment often seems to overshadow the development of a deeper, contextual understanding of individuals' lives. This focus can limit meaningful engagement with alternative framing of their preferences and lived experiences (Newbigging and Ridley, 2018).

In situations where a patient is not taking medication because of their doubts as to the nature of their mental illness, an AMHP will proceed with a detention application under Section 2 to allow doctors to assess the person:

> He wasn't taking medication he had been [on] because there was a question whether this is ADHD - is this behavioural? Is this psychosis? So, I felt that the Section 2 will give the doctors time to assess exactly - find out what exactly is this. Is this psychosis? Is it ADHD? Is it behavioural? And the risks as well, like I have explained. (Eve, a Black female AMHP with eleven years of experience, Site 1)

Despite the uncertainty surrounding this person’s mental illness, the AMHP mobilised the language of risk, applying it to the person’s situation to legitimise (Stanley, 2018) their detention decision.

The interview data indicates that the uncertainty of risk drives detention decisions. This was demonstrated during my discussion with Yasmin – a Black female AMHP with six years of experience - regarding the delicate and complex nature of decisions regarding risk, with a service user’s history of ‘risky’ behaviour featuring in future decisions about detention. She narrated her experience of initially opposing medical recommendations by choosing an informal admission instead of detention, only for the service user to escape by smashing the window of the vehicle transporting him to the hospital. She described having a good discussion with doctors about the reasons why she felt informal admission would have been a good idea for him, but ultimately “the risk of him doing something like that again” prompted her to make an application for his compulsory detention.

When making detention decisions, AMHPs consider the nature of the risk they are dealing with, while applying their risk knowledge to decide whether to consider a social perspective or a recovery model. Participants admitted that it was difficult to manage risk to others when accounting for social perspective, as illustrated in the following quote:

> Usually, there's always a risk to deteriorating mental health and you have to kind of see where that person's at the moment. Is that a risk you can reasonably take without the situation getting too – getting bad, worse? When you're talking about risk to others that they may pose, it's sometimes difficult to see how social circumstances might be able to mitigate those. (Yasmin, a Black female AMHP with six years of experience, Site 1).

This appears to support Karban and colleagues' (2020) assertion that, in the assessment and management of high-risk cases, social perspectives may become secondary considerations for AMHPs. In contrast, when a person is deemed to be at risk to themselves, AMHPs are more likely to engage in positive risk-taking, utilising the social model to consider less restrictive options than if a person were considered 'risky' or a risk to others. The majority of AMHPs will choose to detain a person if they perceive their behaviour and presentation as aggressive and dangerous. In situations where AMHPs believe an individual undergoing assessment poses a risk to others, including family members, they will classify the case as high risk and apply for the person to be detained in the hospital:

> Following the assessment, I had a discussion with the AMHP about the reason for her decision to make a section 3 application…the AMHP explained that "*the patient is not managing his mental illness and poses risk to others. He physically and verbally assaulted an elderly neighbour*" (Fieldnote 13, Week 8, Site1).

> So, he's very aggressive and poses risk to others. Erm, I mean, he's previously assaulted girlfriends in his property - previously assaulted another person within – and staff within the supported living that he's in. So, potentially, he can be a significant risk to others. A risk to self is that he's self-neglecting, doesn't maintain his personal care and doesn't maintain his environment. But there is

> a significant risk to others when he does become unwell because he becomes incredibly paranoid. (Bridget, a white female AMHP with eight years of experience, Site 2).

These extracts reveal that the AMHPs rely on the MHA criteria stating that a person ought to be detained “with a view to the protection of others” (DoH, 2015, pg. 113). Public protection was central within AMHP decision-making and their conceptualisation of risk, concurring with the findings of previous studies (Coffey, 2012).

While a service user’s vulnerability or their indicators of risk to themself provided the justifications for detention decisions, the majority of AMHPs in this research constructed risk through their anxieties relating to their uncertainty as to a person’s mental health condition; as well as their concerns as to an individual’s risk to the public if they remained at liberty. Notably, this precautionary approach was intensified when it came to Black service users, who were disproportionately constructed as representing a risk to others rather than to themselves. This racialised construction of risk reflects deeper systemic biases, wherein Black individuals are more readily associated with danger or violence - reinforcing harmful stereotypes that shape clinical decision-making (DHSC, 2019c).

5.4 Managing risk in the community

This theme explores whether risk can be managed in the community rather than detaining a person based on their current behaviour, the nature of the risk professionals are dealing with, the availability of community resources, and the feasibility of not detaining the person under assessment. A sub-theme – *a family’s ability to manage the risk* - concerns the role of a person’s family in mitigating potential risk or danger while in the community; this is an important consideration because families are vital for both managing and exacerbating such risk.

During the MHA assessment process, AMHPs consider the practicality of not detaining a person while reviewing their current behaviour and their risk to others in the community. They also explore the service user's emotional state, as well as their professional anxiety over the uncertainty of predicting what a person 'might do' if they considered less restrictive options, such as accessing support in the community instead of involuntary hospital admission.

A consistent feature that emerged in both the interviews and the observational data was that AMHPs wanted to know if the risks presented by an individual could be managed in the community. When making decisions regarding whether to detain a person, the AMHPs acknowledged that their role required exploring all viable alternatives to compulsory admission, and whether there were community services – including a home treatment team – available to support the person while considering the potential risk they presented. When asking AMHPs what relevant influences and circumstances were considered when deciding whether to detain the assessed person, their responses suggested an unwillingness to take any positive risks to keep the service user in the community unless they could be fully satisfied that the assessed individual could live or be safely managed within the community:

> During the assessment process, you always have that in the back of your mind as you're assessing the patient. You're asking yourself, what are the alternatives? Is it safe for this person to be treated in the community? (Vivian, a Black female AMHP, Site 1).
>
> It wasn't safe for him to be treated in the community… why it wasn't safe is because he was frantically trying to run away from – actively trying to run away from people that he thought wanted to kill him. (Venus, a Black female AMHP with five years of experience, Site 1).

The AMHPs appeared to focus on the concept of “absolute safety” (Warner, 2007, p. 30), echoing many historical policy documents such as the Department of Health’s 1998 white paper on mental health policy titled ‘Modernising Mental Health Services’.

The extracts above suggest that AMHPs contemplate the uncertainty shaping potential risk, and whether there are viable alternatives for its management within the community. There seemed to be heightened anxiety among the AMHPs about their responsibility to “manage the risk” or keep a person safe in the community following a referral or medical recommendation for MHA assessment, as illustrated in this fieldnote:

> The AMHP commented crisis team wanted to shirk their responsibility and didn’t want to manage the risk until Monday - that’s why they are pushing for MHA assessment on Friday evening… this job is very sensitive, so you always have to be very careful and contextualise all the different scenarios, factors, and time when discussing referral information, because once the AMHP team accepts a referral we have to manage the risk [in the community] until the patient is conveyed to hospital [admitted]. (Fieldnote 3, Week 3, Site1)

It was noted that the AMHPs appeared to draw on their risk knowledge, not only to classify the level of risk presented by a service user but also to control future uncertainty. For the AMHP in the following extract below - and most of the practitioners interviewed - managing risk in the community was connected with regulating the worker’s anxiety (Brown and Gale, 2013). Consequently, decisions relating to risk legitimised detention even before an event occurred (Stanley, 2018). For the AMHPs, this implied worry and anxiety over what might occur necessitating immediate intervention because of future uncertainties:

> I was considering what she might do, again, because she was aggressive. There are vulnerable people in the hotel. Also, even the staff could be vulnerable if she kicks off. So, I'm looking at all that, and my stress level as well - I am not immune to that. So, I was looking at everything that will happen, if

> she's not admitted and treated immediately. (Mary, a Black female AMHP, Site 1)

The AMHPs avoided taking a positive risk to allow a person to be kept in the community for support and treatment when referral or the medical recommendation deployed risk language, or if the person had a history of referral and admittance to a Psychiatric Intensive Care Unit (PICU) which they saw as synonymous to ‘high risk’. In such circumstances, the AMHPs would undertake a risk intervention by contravening a person’s wish to remain in the community and their right to private and family life enshrined in Article 8 of the Human Rights Act 1998. There was evidence that some AMHPs constructed a priori decisions about risk levels, using referral information to justify their decisions to opt for restrictive options without considering community services and other detention alternatives, illustrated in the following observational extract:

> When I asked the AMHP whether they have considered all the least restrictive options and community services, she bursts into laughter, and instead of answering my question, she responded by asking, “Why would you think based on how she is presenting now, she could be contained in the community?” I did not expect this response from her. I answered that I was not implying the patient could be contained in the community or not, I was just wondering whether alternatives to detention have been explored. The AMHP said that “although the patient said she wanted to go home, based on how she was presenting, and based on the fact she is on 2:1 support, with constant observation to manage her risk, and she recently had to be referred to PICU (intensive unit), the option of alternative to hospital is not there at this point. I wouldn’t have even offered her because the risks are very high, because most patients on the ward are under 1-hour observation and the fact, she’s under constant observation tells the level of the risk she presents” (Fieldnote 5, MHAA, Week 4, Site 1)

While several AMHPs mentioned the need for “positive risk-taking” they felt this was only possible if the person could be supported by others managing their risk in the community, as Vivian – a Black female AMHP with one year of experience - explained:

> There is something that we call positive risk-taking. So - and who else is there to support that individual, to manage those risks, you know, prior to the assessment to see whether the individual can be managed in the community?

Participants admitted to devising methods - often independent of the relevant legislation - to minimise risk. This can sometimes include coercive means to prevent risk escalation where there is uncertainty. From a “risk work” perspective, the AMHPs attempted to circumvent the limits of their risk knowledge when adopting other means of managing uncertainty (Veltkamp & Brown, 2017) such as engaging in risk-averse or defensive practices (Warner, 2015):

> …as professionals, you want to minimise things [that might] escalate, you're trying to not make things escalate. So, in the end, you're like, “Oh, just come with us. It will only be a few days, and you won't last a longer day - a day longer than necessary. Just come to hospital with us”. And before you know it, six months later, that person has gone through Section 2 - they are now on Section 3. […]
>
> Interviewer: So, when professionals are giving this information, do you think that they are really aware that it's not going to be just some few days that they are suggesting?
>
> Participant: Most of the time, yes.
>
> Interviewer: So, there is – so, you're alluding to the fact that sometimes there is –?
>
> Participant: There can be coercion. You wouldn't want to be that practitioner who is using coercive practice, but what can you do to try and make sure that this – that [what] you're trying to do goes as smoothly as possible - so you want the whole thing to go as smoothly as possible. So, you may end up using coercive language, as you said. (Venus, a Black female AMHP with five years of experience, Site 1)

When there is disagreement with doctors over whether a person should be detained or remain in the community, AMHPs sometimes use veiled threats and coercive language towards service users, forcing them to do something to satisfy the doctors that a person could continue living in the community:

> So, ultimately, they didn't do any medical recommendation and I think one of the concessions that we agreed was that we were going to say to [the service user] firmly that he needs to go to the GP and get weighed and stuff just to rule out any physical health issues, or else it's a low threshold to come back, which is almost a threat but it was something like a middle ground to appease the doctors and the mental health team… So, I did actually - as a compromise - say to him you need to do this, and he agreed. (Jason, a Black male AMHP with five years of experience, Site 2)

AMHPs using "coercive language" as a tool during risk intervention can ultimately affect client relationships and cause suspicion, mistrust, and nonengagement, ultimately undermining a practitioner's ability to understand the risks concerning that individual (Heyman *et al.*, 2012; Brown and Gale, 2018).

5.4.1 The family's ability to manage the risk

This section focuses on the family's capacity to contain risk. Notably, the potential tensions within families exacerbating risk that were identified in earlier literature (Solanki, 2020) did not arise in the data.

It was evident that one of the things AMHPs considered while making decisions about whether to detain the person undergoing assessment was the likelihood for carers or family members to manage the risk in the community. Whilst the AMHPs acknowledged the lack of easy solutions when forming judgements containing risk uncertainty - particularly in cases possessing suicidal ideation – their decisions were facilitated by strong social support networks comprised of family members living within the household and community resources:

> I think where it becomes tricky if someone is suicidal - because they may tell you today that they're not going to do anything, they are not feeling like that. But you know, risk is dynamic. You ask yourself, "what is going to happen if this person by the time they get home - start feeling suicidal again?" So, you have to be sure within yourself that – have I given this person enough resources that

> if they do feel suicidal, they're willing to reach out and ask for help? Or do they have someone in their house who supports them, that if they do feel suicidal, there is somebody that they can go and talk to? So, I think that judgment is very difficult and there's no easy answers. (Venus, a Black female AMHP with five years of experience, Site 1).
>
> The minute you get a referral you're – you know, the risks have usually been identified. It's how – is there anything in that person's situation that could mitigate those risks or could reduce those risks to a manageable level to avoid a hospital admission? (Yasmin, a Black female AMHP with six years of experience)

Although participants felt unable to eliminate risk due to its dynamic unpredictability, there was consensus that having adequate family support eased the pressure on the AMHP making the decision. In circumstances where AMHPs felt a service user required hospital admission, this decision was impacted by the family's ability and resources to contain the risk in the community. This was evident in my discussion with Pamela, a White female AMHP with 18 years of experience, regarding her response if the nearest relative challenged the detention of a loved one. She cited her experience of needing to accept a parent's objection to such a decision owing to their ability to care for their son in the community. To this AMHP, the role of the family in containing risk was central to her decision-making:

> I spent most of the day [laughs] on the ward talking with the family. And at the end of it, I thought I can't say it's an unreasonable objection because although they – it was the mother and father – although they know that their son isn't well - isn't fully well but he's going to live with them, they're going to look after him, they say they know how to contact services. I can't say that it's unreasonable if they're actually looking after him.

Participants as a whole tended to decide on detention for someone if their family members or parents raised concerns about the person's safety within the home, or the risk presented to them and their household by the service user, as in George's account:

> I asked Mum, “what do you think should happen for now? Because from where I’m sitting you could see that your son... initially he said he wanted to go home, toward the end he said he wanted to come into hospital. So, what is your view about this?” She said, “really, I will do that, my son need to be in hospital. I’m quite worried that I may not be able to contain the risk at home because he is quite - he is a man, I’m a lady. He can overpower me if really the thoughts are strong that he can’t cope, he can overpower me and jump”.

It is worth emphasising that focusing on risk as the key determinant in AMHP decision-making is standard and applicable to all mental health service users, but my analysis of the data demonstrates that practitioners’ classifications of risk were strongly influenced by service users’ race and ethnicity. This is explored in detail below, under the theme of the racialised risk assessment.

5.5 Racialised risk assessment

This section focuses on the specific role race and ethnicity play in MHA risk assessments, AMHP decision-making, and its implication for Black service users.

According to the participants, racial discrimination features prominently throughout the MHA assessment process both at the referral and judgment stages. During my interaction with Kevin – a Black male AMHP Lead with eleven years of practice experience (Site 1) - regarding his involvement with service users from Black communities, he provided a powerful account of how mental health professionals continue to exploit negative stereotypes of young Black men as “Black, big, and dangerous” when constructing risk and deciding an appropriate course of action or intervention:

> It's quite disheartening when you see that even though the system is set up to help all races, there is a bit where some type of heavy-handedness is meted out upon - especially young Black men when they come for a service. One example being a Caribbean gentleman who came to the [site]. We were based

> in [location] and I got a call from the mental assessment team manager to come and detain the person, because the referral stated, “big Black man, speaking loudly in Patois, and basically making himself a nuisance”. And I asked, “why are we being called to come and do a Mental Health Act assessment on a patient who has come to see their doctor? And the doctor doesn't want to come down because the doctor's reason being the patient is being sexist or doesn't respect women and talking down?” I said, “this doesn't require a Mental Health Act assessment” and this became a very huge argument between professionals, between myself and the manager. Because this is an Irish Caucasian woman making this referral, putting it in the medical notes, in bold, “big Black man speaking Patois loudly” as a referral for a Mental Health Act assessment. I said, “You can't do that, take out - his big Blackness out of it. Take out his Caribbean background - out of it and tell me what the risks are. Because this is why we are coming to assess, not the description of that human being”. And I said to them, “if this was a middle-class white man coming into the place with a loud tone being disrespectful to women, you wouldn't have called me to come and detain him. You would have called the professionals to come and talk to him and escorted him out of the building, but because this was a ‘big Black man…’”

As the AMHP notes, mental health professionals continue to classify and define risk according to people’s colour and ethnic background. The extract demonstrates that young Black men continue to experience unequal risk assessments compared to their white counterparts, receiving the inferior mental healthcare provision highlighted in the supporting documents of the independent review of the MHA 1983 (DHSC, 2019c). It is significant that while this AMHP was able to challenge this act of injustice - perhaps because of his experience and ethnic background - this study reveals that the majority of its AMHP participants were unable to use their autonomous decision-maker statuses to do similar.

Participants also discussed how racism is embedded within the MHA assessment, especially from medical professionals who tended to unfavourably construct risk concerning Black people compared with the white majority population. Amber, a Black female AMHP with ten years of experience (Site 2) recounted her involvement in an

MHA assessment where other professionals in the team, especially the doctors, made decisions containing racial undercurrents:

> It's interesting for me to observe how I think other people are looking at the person, to the point that I question - I'm like, “would you, doctor, be saying this or making this decision if the person's skin colour was different...?” I see that, oh, you said that about that client. But I would have expected you to say the same thing about this client because there's not that big of a difference. So, why are you saying that and this? Is it because of maybe race or something else? So, I'm able to sometimes see the difference from other professionals. But for me, I try to be – you know, treat everybody with respect, irrespective of race.

While Amber alluded to trying to be fair and adhere to the MHA 1983 guidance to treat people with respect and dignity regardless of their race (DoH, 2015), she did not demonstrate how she was able to challenge or withstand discriminatory practices from other professionals who continued to violate the MHA principles by making race-based decisions. Social workers hold a responsibility to promote social justice for the service users they work with, including an obligation to challenge any form of racial discrimination or act of oppression rooted in race and ethnicity (BASW, 2021), so I would expect Amber - a social work AMHP - to translate this into practice. However, it is notable that professionals feared discussing racism safely and candidly or challenging the unchanged “stereotypical views” about Black people highlighted in previous literature (Keating and Robertson, 2004, p. 445).

The AMHPs also cited the tendency of clinicians to associate Black people’s behaviour with criminality instead as a facet of their mental illness:

> …I've been in situations where a doctor is more likely to criminalise somebody's behaviour - a minority, ethnic person's behaviour - rather than attribute it to mental illness. Whereas maybe if you see somebody who is white, they're more likely to say, “oh, it's because of the illness” and not necessarily criminalise it. So, that's where I often see the bigger difference. (Amber, a Black female AMHP with ten years of experience)

The evidence of race-based decision-making, coupled with the misinterpretation of lived experiences of marginalised groups - especially Black people - represents a form of epistemic injustice. This reflects what Fricker describes as 'hermeneutical marginalisation' (2007, p. 153) where there is unequal participation in the collective interpretation of meaning, particularly concerning significant aspects of the social experiences of disadvantaged groups.

The narrow-focussed, race-based construction of risk within MHA assessments is supported by the following fieldnote observation:

> Mary, a Black female AMHP of twelve years, talked about one of her cases where the consultant was expected to discharge the patient when the period for assessment under Section 2 was due to expire. The doctor asked her to make an application for Section 3 so that the person could be placed under CTO upon discharge. The AMHP felt that it was unfair to make further application for compulsory detention, as the patient had made progress during the assessment period and that the doctor had a perception of the patient relapsing in the community and presenting risk to others - so he wanted him to be monitored in the community under CTO. Mary recounted that when she refused to make the application for Section 3 there was so much pressure from the managers and other colleagues trying to persuade her to reconsider her decision, but she stuck to her guns and “prayed to God that nothing bad should happen to this patient” – relying on faith. The AMHP felt that it is not right to circumvent the law and deploy other measures to restrict/control a patient under CTO when they clearly do not meet the criteria for that. The AMHP perceived that the consultant would not have made the same recommendation or suggestion if the patient (from BME) was a white person. (Fieldnote 1 Week 1, Site 1)

This participant’s use of the word “unfair” in this context reflects the injustices and the restrictive and coercive interventions that Black people experience within mental health services, not only in hospital settings but also in the community. According to Mary’s account, there was no evidence that this Black service user met the criteria for further restrictive intervention upon discharge and that the professional anxiety about his possible risk to others was based upon perceptions associated with his race and ethnicity. While this was not explicitly expressed by the mental health professionals, their attempts to "circumvent the law" to ensure the person remained contained or monitored in the community by using CTOs epitomised the disproportionate application of these powers on Black people, described in the literature as coercive, discriminatory, and race surveillance (Mind, 2018). It is conceivable that the reason most of the study's AMHP participants struggled to challenge these forms of injustices towards Black people, in particular, is because this required confronting not just merely doctors but the entire architecture of clinical managerial practice.

Despite policy initiatives including the 2005 Delivering Race Equality programme and the implementation of the Equality Act 2010, the observational data supports that the long-standing issue of the overrepresentation of Black people in the more restrictive aspects of mental health care and ethnic inequality in service experience (Bhui *et al.*, 2018) remain unaffected. While talking to AMHPs on the first day of my fieldwork regarding my research and objectives, they were very open about the ongoing discriminatory practices they witnessed during MHA assessments and professionals' perceptions of risk relating to Black people:

> Upon hearing my research topic and objectives, George [a Black male AMHP with ten years of experience] said, "when I first became an AMHP about ten years ago, one of the things I was curious about was overrepresentation of Black people within the mental health service. During the course of my practice, I have realised that something that a service user from BME did over 20 years ago will continue to follow him – clinical history, history of aggressive behaviour will be factored into current assessments". He also raised concerns about how "they" [BME service users] are treated and perceived by mental health professionals and police officers [as risky]. "There is heightened anxiety about risk presented to self and others, sometimes just because the patient is Black". He expressed the view that "police officers use excessive physical restraint and too much force when detaining Black people". He highlighted that "the experience of Black people coming into hospital is not good at all". (Fieldnote 1, Week 1, Site 1)

This extract not only illustrates the racialised risk assessment for Black people but also the raced-based discrimination defining their experience of involuntary hospital admission, following adverse pathways into mental healthcare epitomised by the common role or involvement of police previously identified in the literature (Rogers and Pilgrim, 2014; DHSC, 2019).

5.5.1 Professionals' perception of lower risk threshold for Black service users

This section explores AMHP accounts concerning thresholds for risk. There were vivid descriptions of relatively lower thresholds being operationalised for Black service users, resulting in significantly greater MHA use for this particular social group. When talking about his experience of working with service users from Black and minority ethnic communities, Jason – a Black male AMHP with five years of experience (Site 2) - explained that the threshold for Black people's assessment under the MHA is very low owing to professionals' lack of cultural understanding and negative perceptions of Black people's behaviour, often resulting in more detention for people from those communities. For Jason, some referrals and medical recommendations for compulsory admission of Black people have nothing to do with their mental disorders, but are rather due to their race and professionals' prejudices towards them:

> I think they are – Black and ethnic minority, erm, are at a disadvantage of being detained more times, and erm, what's the word? I think they are viewed differently to [their] white counterparts in terms of thresholds for Mental Health Act assessment. The fact that they're dangerous – I do think all these things come into play for service users when you - when you're from Black or ethnic minority group. It's quicker to be referred and you are seen – culturally you have a lot of practises that myself - from a, erm, Black perspective - that I see as totally normal within our culture, that I sit in Mental Health Act assessment and

> even doctors - what they are writing in the med rec and, erm, that's not to do with their mental illness… the threshold is low to detain [Black] people.

Bridget, a white female AMHP with eight years of experience at Site 2, described her experience of assessing people from Black communities, supporting the notion of a lower risk threshold for triggering MHA assessments for Black people and the racial discrimination experienced within the mental health system. While most professionals would not construct risk or explicitly make detention decisions based on people's "skin colour", the AMHPs discussed how institutional racism impacted risk assessment, as well as other factors affecting their decision-making such as the influence of medical practitioners within the assessing team:

> If you look at the wording of the Mental Health Act, particularly for a Section 2, you and I in any given moment of the day could meet the threshold for detention. The threshold for detention is incredibly low but it is about how do you as an individual equate that with the risk… I'm going to be honest with you, P, I have experienced like white guilt because I will never know what it's like to be an ethnic minority in 2022 Britain. But I can acknowledge that there is discrimination. I can acknowledge that when I put in a police risk assessment, I know that if they're a forty-year-old white person, erm, they'll send two officers, if it's a forty-year-old Black man, they're more likely to send six police officers. So, that perception of risk is institutional. But I would like to think that as a practitioner, I assess people based on their need as opposed to their skin colour. But I'm – but there are so many influences on that. Erm, remembering that we are part of an assessing team. That there are so many influences on your decision-making.

As illustrated in the extract above, Bridget discusses the low threshold for detention under Section 2 of the Mental Health Act (MHA), which permits the compulsory hospitalisation of a person for up to 28 days for assessment if they are deemed to be suffering from a mental disorder that justifies detention and if it is considered necessary for their health or safety, or for the protection of others (Brown, 2016). She raises concerns about how broadly the law can be interpreted, suggesting that its criteria are so expansive that almost anyone could technically fall within its scope at any time. This highlights the potential for misuse or overreach. Bridget further underscores the subjective nature of assessing "risk" in mental health contexts, emphasising how personal biases and judgments can lead to inconsistent decisions and disproportionate, potentially harmful interventions. These risks are particularly pronounced for Black individuals, who are often disproportionately affected by such assessments (Singh & Fazel, 2010; Barnett et al., 2019). As a White female professional, Bridget reflects on her own racial privilege and describes experiencing "white guilt," acknowledging the limits of her understanding of the lived experiences of ethnic minorities. Nevertheless, she demonstrates reflexivity and a willingness to confront difficult truths, affirming the existence and impact of systemic discrimination.

Crucially, the application of a lower risk threshold in MHA assessments - especially in relation to Black individuals - may partly explain why people from Black communities are more frequently subjected to compulsory hospital admissions, as highlighted by previous research (DHSC, 2019; Webber and Huxley, 2004).

Due to the low-risk threshold for detention and fears of miscalculating danger, it is problematic for professionals to “speak back” to the risk narrative because not constructing a case or classifying a Black service user as risky and requiring compulsory admission could be deemed poor practice should bad outcomes occur. The perceived ‘riskiness’ of Black service users translates as increased risk to a professional who may suffer harsher consequences for bad outcomes perpetrated by Black service users compared to those by white counterparts, due to racialised risk or public safety agenda. If Black service users are hyped as high-risk individuals requiring restrictive intervention even in the community - as reflected by the disproportionate use of CTOs against them (DHSC, 2019c) - AMHP decisions concerning this particular social group will be more defensive, for fear of making a mistake which could damage an organisation's reputation (Brown and Calnan, 2013).

Challenging risk knowledge during MHA assessment can be problematic with many unexplored ambiguities remaining around the validity of the risk knowledge. Jason, a Black male AMHP with five years of experience, explained that AMHP decision-making and risk interventions are not exposed to enough questioning about how the risk threshold criteria are so low:

> I think we don't get challenged enough as AMHPs. I think we don't – we have too much power, to be honest, we don't get challenged enough about why you're making decision - what about this? This is what the service user is saying. Because the threshold is so low to detain [Black] people.

The MHA (1983) Code of Practice encourages AMHPs, and other professionals involved in decisions relating to detention to consider the least restrictive options and alternative mental healthcare provisions maximising independence. This section highlights that despite decades of investment to try and realise this, there is evidence of racial disparity and lower risk threshold when utilising the MHA for Black people (Bhui *et al.*, 2018).

5.5.2 Black service users' experiences of professionals' risk assessments

My interaction with Black service users regarding their experience of assessment and detention by AMHPs indicates the elements of discriminatory practices and other forms of injustice they often suffered at the hands of mental health professionals, including AMHPs. During my interaction with Wesley, a 55-year-old Black service user with a diagnosis of schizoaffective disorder, regarding his experience of being detained, he recounted racism from both the police and his MHA assessors:

> My first detention - I have been in love three times, and the second one was a Ward Sister – a Registered Nurse for the mentally handicapped. And she was an actress and we fell out - we had an argument and she called the police. Let me tell you about racism; they heard her voice - because she was an extremely white middle-class [woman] - and they saw me as a Black man. And they arrested me and I didn’t do anything… Do you know what plums in the mouth are? It means extremely middle-class and she was charming, and they saw me as a Black man and they arrested me. And I didn't do anything! And that's the first time I experienced racism - proper racism. I would have been about 23 [years old].
>
> Interviewer: So, when they arrested you, what happened after that? What led to you going into the mental health institute?
>
> Wesley: My wife said I was mentally ill, and they would listen to her [and not me] because she's a professional. So, erm, I went to [a site], I don't know…., it’s somewhere in [location] which is a psychiatric hospital for threats to kill.

For this service user, his admission was involuntary and based on his social status, class, and race, not least because he required assessment and treatment in a psychiatric hospital. He is a Black man with a diagnosis of schizoaffective disorder, so he experienced dual discrimination by being Black and having a mental illness. This is a clear example of testimonial injustice - itself a form of epistemic injustice - in that his account or testimony was assigned diminished or non-existent credibility; Fricker (2007) calls this a “credibility deficit” owing to negative stereotypes associated with his social group/race, whereas the testimony of his partner, from a white middle-class background, was disproportionately afforded greater, inflated credibility.

While observing an MHA assessment undertaken by Bridget, a white female AMHP lead with eight years of experience (Site 2), on a young Black male service user (Finn, aged 22), he talked about how the injustice within the ward and the unfair treatment he had received from the mental health team have disempowered him to the extent he did not even see the need to appeal his detention. He alluded that his continuous admission was based on his race, as he has observed other patients from Caucasian backgrounds being discharged home, despite their higher risk level:

> Bridget explained to the patient that it is likely at the end of the day, he’s going to be placed under Section 3, and she presumes the patient is going to appeal. Finn replied, “No because there’s no need to appeal, and whenever they decide to let me go out, I will”. Finn commented, “there’s so much injustice in here, I have seen some people who have done worse things than mine”, yet they have been allowed to go back home. He said one white male who threw his urine at him and threatened to stab him as well has been discharged, but as soon as he reacts to attacks on him “in self-defence”, staff would put him in seclusion. (Fieldnote 4, Week 2, Site 2)

The above extract describes that staff accorded higher credibility to the white male’s testimony and gave low credibility to Finn’s account of what caused the violent incident between the two in-patients. According to Finn, this was because his behaviour in response to or in “self-defence” from the attack by a white male was undeservedly classified or constructed as risky, owing to prejudices held by staff about his social identity suggesting epistemic injustice.

Prejudicial stereotypes associating Black service users with violence often lead to disproportionate and unnecessary police involvement during Mental Health Act assessments, as illustrated by the following quotation:

> I think the ambulance people called the police for their own safety, but I wasn’t going to harm anyone, you know, but I think that’s just how they see us. (Sean, a 26-year-old Black service user, site 1)

Sean’s account suggests that the ambulance crew may have perceived him as a threat or risk to others, even though he insists he had no intention of harming anyone. This indicates a disconnect between how Sean sees himself and how professionals perceive him, possibly driven by implicit bias and fear. His account also seems to suggest that his identity as a Black man may have influenced the ambulance crew’s decision to involve the police. Evidence suggests that Black people, particularly in mental health crises, are disproportionately more likely to have law enforcement called on them, which often escalates situations rather than de-escalates them (Nacro, 2007). The service user seems to have experienced a sense of criminalisation rather than support when seeking or receiving care. This perception could erode his trust in mental health services, potentially creating a cycle of disengagement (Keatin and Robertson, 2004) from the very support he requires.

5.5.3 Black professionals' empathic understanding of risk as perceived by Black service users

It was also clear in the data that in cases where families or nearest relatives from a Black community had initiated a referral due to their concerns about the risks of an individual, it raised the likelihood of AMHPs choosing detention. This was evidenced during my discussion with Yasmin, a Black female AMHP with six years of experience, regarding the factors or reasons leading to her decision to detain a Black male service user under assessment. She gave an account of the complexities around risk regarding the role of the police in mental health and the structural inequalities already identified by previous literature detailing Black communities and policing (Fernando, 2017; Singh *et al.*, 2013). She conceptualised or read a level of risk from a Black woman’s decision to call the police on her son, explaining that the mother knew that she was potentially exposing her child to all the awful things that the police do to young Black men, and therefore, informing her - the professional - how high the risk might be for the family. She seemed to suggest that the decision for any family about referring their child would be potentially really difficult, but for some families, there are different equations, with this family from the Black community having to weigh up the risks associated with calling the police against not doing so:

> One of the key things is when I did finally speak with Mum, she had actually called the police herself being concerned about him, about how well he was, and I remember coming back and speaking with my colleagues the next day. And I said I had to think about the fact I have a son, I have a Black son, and for me to be a mother and to call the police on my Black son there would have to be a strong, strong reason for me to do that knowing about, you know, Black people's experiences in police custody, what could potentially happen, his reaction to police. So, I kind of felt like if she had been – because she had been that person to call, his behaviour wasn't manageable by the family, they were actually scared of him. He'd been assaulting people, you know? So, there was a risk to others.

In this example, Yasmin, a Black professional, deemed young Black men's experiences of police involvement to be fraught with fear and adverse outcomes, and that parents from Black communities would not initiate police involvement unless the risks became "unmanageable". It was also evident that among other factors, this AMHP appeared to use her personal experience regarding her ethnic background and empathic understanding to conceptualise risk and arrive at her detention decision. There is a strong flavour of fellow feeling in this extract; what the AMHP describes is assessing this family's level of risk by the fact the mother is prepared to take the significant step of reporting her son to the police, and that she - as a person from the Black community - has an acute awareness of the very high risks he faces from law enforcement. The AMHP comprehended this as an indicator of elevated risk, in contrast to what her reading would be if the family were white. This section highlights the idea that risks are mitigated and intensified very differently depending on a service user's race and ethnicity, particularly in terms of a community's experience of and response to police brutality.

5.5.4 Professionals’ perceptions of dangerousness and ‘risk to others’

Closely linked to the lower risk threshold MHA assessment operationalised for Black service users is professionals’ perceptions of dangerousness regarding young Black men in particular, and its impact on their decision-making about detention. In theorising the relationship between the concepts of dangerousness and risk, Douglas (1994, p. 24) describes risk as “danger”, and high-risk as "lots of danger”. Dangerousness has now been absorbed into the risk discourse, and professionals’ risk thinking about mental health and Black service users in particular – who are predominantly classified as a risk to the public. There was an acknowledgement by the AMHPs that professionals’ approaches to MHA assessment respecting Black people suggested that they drew on racialised negative stereotypes and perceptions of dangerousness (DHSC, 2019c). Service users from a Black Community presenting challenging behaviour similar to that of their white counterparts is often recorded in medical records in escalating terms. While the risk criteria outlined in the MHA require professionals to consider ‘risk to self or others’ (DoH, 2015), the data suggests that the key distinction in how professionals assess risk for Black individuals lies in their perception of them as potentially dangerous, viewing them as posing a risk to others rather than to themselves. In other words, what sets apart professionals' risk evaluation for Black people is the tendency to view them as a threat to public safety:

> I’m going to be frank; I see – I go in and it’s [a] white or European person or whatever, raising their voice, being aggressive, or agitated - not aggressive. And when you read the med rec there’s no mention of that or it’s not highlighted, or you don’t see the worry about “let’s interview them through the cell” and stuff. A Black person doing a similar thing in the assessment, then they’re aggressive and it’s their mental illness. When I sit there and I think they’re just passionate or, yes, they’re agitated but they’re not threatening, they’ve raised their voice. Or even if they are agitated or even if they are aggressive, that is mentioned more or highlighted more when you’re a person of colour compared – from my

> experience – compared to a white counterpart doing the same behaviour. So, those are the things that I think how they're treated differently. (Jason, AMHP, Site 2)

When professionals describe risk in escalating terms for Black people, it inevitably increases MHA assessments and compulsory hospital admission. The AMHPs believed that some professionals perceive Black people as dangerous and therefore posing a risk to others. This was integral to the translation of risk knowledge in their daily practice.

> He was Black [patient], I was Black, one of the doctors was an Asian female and the other doctor was a white male. And initially I felt – I didn't feel particularly threatened by him but the white male doctor kind of made a comment about whether we could really interview him without police. I was then mainly kind of conscious of how he may be viewing the patient (Yasmin, a Black female AMHP).

My observation of a discussion between professionals within the assessing team and police officers prior to an MHA assessment for a 55-year-old Black male with mental health difficulties suggested that some, including police officers, continue to draw upon negative stereotypes particularly associated with Black males being "big, Black, and dangerous":

> The AMHP (Amber) shared that this was a Section 3 assessment in respect of a 55-year-old Black male of Caribbean descent. The Police officer asked the AMHP, "What does he look like – big, aggressive, intimidating?" The AMHP responded that he doesn't come across as intimidating or aggressive. (Fieldnote 5, Week 4, Site 2)

In the extract above, the AMHP simply stated the individual's age and racial identity, without referencing any specific risk factors. However, the police officer's immediate response or enquiry appeared to associate these characteristics with potential dangerousness or risk to others. Notably, there was no enquiry into whether the individual was experiencing suicidal ideation or engaging in self-harm - issues seemingly outside the officer's focus. Instead, the identification of the individual as a

Black Caribbean man appeared to elicit assumptions of violence, as reflected in the officer’s descriptors such as “big,” “aggressive,” and “intimidating.” These terms echo longstanding racial stereotypes portraying Black men, particularly of Caribbean descent, as inherently threatening or dangerous (Cummins, 2015). Such assumptions, even when unintentional, can shape professional behaviour and decision-making in discriminatory ways.

The construction of risk regarding Black people as dangerous - positioning them as a risk to others rather than to themselves - impacts how professionals engage with this particular social group, often employing coercive interventions to prevent escalation of the “perceived” high risk associated with them (Bhui, 2001). This also constitutes a form of epistemic injustice, as the preferences, experiences, and social circumstances that Black service users deem important are disregarded once they are labelled as dangerous to the public. This dynamic supports Warner et al.’s (2017) assertion that an excessive emphasis on certain risks - particularly the perceived rise in violence linked to individuals with mental health conditions - has overshadowed the broader range of risks that mental health service users face and live with on a daily basis.

History reminds us that professionals’ preoccupation with risk/dangerousness and their use of coercive language and restrictive interventions, particularly for young Black men, can have dire or harmful consequences or serious moral implications. This has been exposed during independent inquiries into the deaths of Black service users detained in hospitals, including David Bennett and Orville Blackwood, whereby there was evidence of undue emphasis on restraints and forcefulness in response to the perceived high risk (to the public) associated with Black people, particularly young Black men (Nacro, 2007).

Implicit racial bias (Hall *et al.*, 2015) and the construction of young Black men as high-risk and dangerous individuals in the community - who pose a significant risk to others - creates anxiety among professionals and often results in defensive practice (Warner, 2007). Many professionals are wary of the assumed possibility that these people - Black service users - will do something terrible to others in the community and that they will be held accountable for it, balanced with the risk that they will be seen as racist for acting in a way that is discriminatory or unjust towards Black people. This tension is illustrated in Mary's account in the previous section on page 124, where the doctor asked her to make application for a Section 3 detention for a Black service user - despite there being no evidence that further detention or monitoring was necessary - solely to facilitate the imposition of a Community Treatment Order (CTO) upon discharge.

It seems that while language about dangerousness may have shifted and some practice behaviours by professionals have altered, the underlying issues driving the compulsory detention of Black people remain. What distinguishes Black people in professionals' risk assessments is the perception of them as a threat to public safety, even when the language of dangerousness is not explicitly used. Interestingly, the data from this study reveals a consistent lack of recognition of 'risk to self' in the assessments of Black service users. This omission reflects a form of epistemic injustice, whereby professionals' risk assessments and prioritisation consistently fail to account for the specific vulnerabilities faced by Black individuals.

5.5.5 Racialised diagnostic and treatment practices

This section addresses what flows from the racialised categorisation of ‘risk to others’ and the lower risk thresholds for Black people previously outlined. The AMHPs and medical professionals in this study described how racial biases are embedded into diagnostic practices, to the extent that Black people are more likely to be diagnosed with schizophrenia than their white counterparts. This finding is consistent with the evidence in the literature that racist attitudes are entrenched in the mental health diagnostic process (Fernando, 2017). Schizophrenia corresponds with the higher risk category and a need for stronger anti-psychotic medication, ultimately impacting AMHP detention decisions relating to Black people. While in a psychiatric hospital to observe a Section 3 MHA assessment involving a Black patient whose detention under Section 2 was due to expire, I had an interaction with the Section 12 doctor involved in the assessment who candidly admitted to racial biases being ingrained in the diagnostic process:

> While waiting for the patient, the doctor asked me about my studies, and I told him my research focuses on the implementation of the Mental Health Act and how the AMHPs make detention decisions in respect of BME people. The doctor looked at me and smiled. He said “I have seen a lot of racial biases within the mental health service. I’ve observed that when referrals come in, certain diagnoses such as psychosis are normally given to Black people whereas white people who show similar symptoms are often given delirium”. The psychiatrist appeared very interested in my research. He talked to me about [BME] people’s religious belief and how it could easily be confused with “delusional” disorders. (Fieldnote 5, Week 4, Site 1)

The above extract also suggests people with similar symptoms of mental illness are likely to experience varying outcomes concerning diagnosis, prognosis, treatment pathways, and the use of the MHA assessment consistent with a person’s colour. It was evident that professionals had limited understanding of the culture and religious beliefs of Black people, often conflating them with mental disorders.

The lack of knowledge and awareness of Black peoples' ways of life, unconscious biases, and prejudices based on negative stereotypes partly account for the overrepresentation of psychotic diagnosis among Black people, as George, a Black male AMHP with ten years of experience, explained:

> I feel like there is a lack of understanding over how Black people come across, how they present themselves, the doctors sometimes do not understand that, and they are very quick of diagnosing Black people with schizophrenia. Erm, quite often they push Black people to take… erm, mainly the Clozapine which is the last anti-psychotic medication that should be used really, without having tried other anti-psychotic medication beforehand to make sure that yes, if they are not responding… Clozapine is the last resort.

The above extract suggests that professionals' perceptions of Black people as high-risk individuals and their implicit biases affect the diagnostic process, and ultimately, their risk intervention, in the form of prescribing the highest dose of medication. According to this AMHP, there does not seem to be any reasonable reason for prescribing high-potency medication to Black people aside from how clinicians perceive this particular group, and their lack of understanding regarding their presentation or behaviour, which has previously been highlighted in the literature (Cohen *et al.*, 2019).

The data reveals professionals' interpretations of Black people as loud and negatively presenting themselves may influence the number of schizophrenia diagnoses given to people from these groups. As George, a Black male AMHP, explained:

> I mean being loud can't be the only symptom that will justify giving somebody a diagnosis of schizophrenia. Obviously, you have to exhibit some psychotic symptoms for the consultant to come down to that but quite often they will call it schizoaffective disorder when people are in that kind of presentation whereby probably they do things… but if it's a Black person exhibiting the same symptom that are attributed to schizoaffective disorder, but when it is a Black person it becomes schizophrenia.

This is consistent with Merino *et al.*'s study highlighting that racialised minorities are underdiagnosed with affective disorders and over diagnosed with psychotic disorders (Merino *et al.*, 2018). However, this research has provided further evidence that professionals' lack of understanding of Black people's behaviour, and associations with high-risk labels, partly account for this.

The diagnosis process is riddled with professionals' pre-conceived ideas, with implicit and unconscious racial biases often affecting diagnosis and ultimately, the decision-making relating to compulsory admission. As Bridget, a white female AMHP with nine years of experience (Site 2) explained:

> When I write warrants for people and I go through the diagnostic criteria, someone could have six different diagnoses in the last twenty years… I think including diagnosis there is lots of presumptions, but I would like to think that when I go out and do an assessment I base my outcome of that - based on – solely on the assessment that I did and of course, there's going to be some of the historic information that I based it on… but consciously I try to be fair. But I think we have to acknowledge that we have unconscious bias that may influence. And as I say, it's not just me making a decision, three people have to agree in order to detain someone.

The above extract suggests that it is not the overtly race-based prejudice by mental health professionals engendering the disproportionate diagnosis of mental disorders and detention of Black people, but rather the implicit biases and racist attitudes firmly established in the diagnostic process. While some of the AMHPs were very aware of this 'over-representation' issue and the diagnosis practices perpetuating racism, they did not demonstrate that they took pains to control and challenge these biases or prejudices, perhaps due to blame culture and the dominance of the medical model within the mental health system. AMHPs found it problematic to exercise their autonomy over decisions relating to diagnosis, treatment, and medication, and sometimes even experienced testimonial injustice from medical professionals assigning less credibility to their knowledge:

> Quite often they push Black people to take… mainly the Clozapine which is the last anti-psychotic medication that should be used really… And when you try to explain to the doctor about these - really because, you know, because you are not medically trained, they don't listen to you really, they don't take on board what you are saying. So, these are the things that I find quite frustrating really. (George, a Black male AMHP with ten years of experience, Site 1)

There is evidence that the overdiagnosis of psychotic disorders among Black and minority ethnic groups is often coupled with their overmedication and high doses of anti-psychotics. It is worth mentioning that during detention, while both white and Black patients are subject to pharmacological restraint and other issues relating to medication, the data reveals that Black service users are disproportionately affected, as Venus, an AMHP with five years of experience, explained:

> A lot of Black patients go through a lot of harsh treatment within the mental health service. She cited instances where Black patients with psychosis tend to be given higher doses of medication as compared to white patients who are similarly psychotic. (Fieldnote 14, Week 9, Site1)

Service user accounts of their experience of detention and mental health care also show elements of racial biases during both diagnostic practices and the treatment of mental illness. Ken narrates his experience of being wrongfully given a diagnosis of psychosis, not based on his presentation and symptoms but rather because of his race. His account exemplifies ethnic inequalities in incidents of psychosis diagnosis among Black people, and the fact that they are less likely to be offered psychological therapies, as highlighted in the independent review of the MHA 1983 (DHSC, 2019c).

> If I was a middle-aged white woman and I need talking therapy, or a Jewish [person] that need talking therapy, I think that will get access to it. I'm more likely to get access to it, but as you know, when you're Black, you're six times more likely I think in London or four times more likely to be given psychosis. I didn't have any hallucinations. I didn't hear any voices, but that's the diagnosis that they gave me. So, there's a lot of statistics that show that Black people are more

> heavily medicated and they're more likely to be given psychosis or schizophrenia as the diagnosis. I wasn't, I don't believe that till this day that I was psychotic. (Ken, Black male service user)

The data has demonstrated that the institutional factors resulting in negative stereotypes and racial biases increase the risk of overdiagnosis of psychotic disorders and overmedication among Black people, ultimately creating rising detention rates.

5.5 Tension arising in AMHPs' decision-making relating to risk

This theme explores the tension between risk management practices, managerial culture, and professionals' ability to work in the best interests of service users, through relationship-based practice facilitating risk minimisation. The AMHPs reflected on tensions emanating from translating and handling risk during MHA assessments and the impact on their practice and the social perspective aspects of their role, which is theoretically rights-driven and user-focused. A managerial culture and protocol-driven practice whereby deadlines take precedence affects both AMHPs' performance and their requirement to involve service users in decision-making:

> Interviewer: if you were less busy, and services were not risk driven do you think service user participation - involvement would probably be more?
>
> Participant: Oh yeah, definitely - definitely. We will spend more time trying to explore the support network, trying to see what resources are in the community. We will spend more time doing that but unfortunately, sometimes we do not have the time to do that because when you've got somebody on 136 for example, and the clock is ticking and they need to be assessed within a certain time, you don't have that time maybe to look around, leave a message, wait for somebody to call back. That's what we are faced with really. (George, an AMHP with ten years of experience, Site 1)

Practitioners described the challenges faced by AMHPs within a managerial culture, with competing tensions over timescales to complete risk assessments and the need to consult with or involve services and carers in decision-making, as illustrated in the extract below:

> Interviewer: What do you think are the challenges, if any, in terms of consulting or involving services and carers in decision-making?
>
> Respondent: Erm, I think there's a pressure on time. I think there's a - kind of, you know, there's always a real kind of hurry up in terms of, you know, completing and getting the outcome of the assessment, (Denise, a white female AMHP and former ASW of 30 years of experience, Site 2).

It is noted that the accumulative paperwork and bureaucratic processes involved in MHA assessments affect AMHPs’ daily practices and decision-making. It creates tension for professionals when translating risk knowledge into practice, and the relationship-based work and user involvement fundamental for effective risk management. As indicated in the following observational data, AMHPs are burdened with sizeable caseloads, with bureaucratic documentation affecting practice. The exchange below among professionals, captured during observation of an MHA assessment in a hospital setting, reveals the onus on AMHPs to meet organisational demands to evidence their decisions, which ultimately affects practitioner’s well-being and performance:

> The doctor gave her report to the AMHP who in turn added his own report and handed them to the ward nurse and said, “there are beds available for both patients”. The nurse reminded the AMHP that there was another patient on the ward needing an MHA assessment. The AMHP does not look impressed with this reminder [saying] “I have had enough today, I’m tired. I will leave that for tomorrow”. He came to stand near me, and said, “it’s about documentation, writing up the evidence for your decision. You have to write it all up so I’m gonna do the third one tomorrow”. (Fieldnote 21, Site 1)

Whilst there is nothing wrong with AMHPs documenting their decisions, extensive paperwork - associated with identifying and managing risk - could become problematic for a practitioner not merely due to time constraints but also their ability to exploit their embodied knowledge and skills for making informed decisions for service users, while promoting their rights and self-determination (Hemmington and Vicary, 2023):

> When you have 35 people and they all have to be seen, and you all have to tabulate something in terms of risk assessments, make sure that things have been updated to kind of have a snapshot. Because audits come from everywhere, every month, audits are coming that you haven't done this, you haven't done this. You basically have no time to spend with them. You're sitting behind a desk writing about them or completing their forms to meet audits as well. (Anne, a Black female AMHP trainee, Site 1)
>
> There are so many assessments coming in that you literally go from one to the next. Then you don't have time and then you get a case and it's like you know if you'd had that time earlier on, we might not be here now. (Jane, a white female AMHP with nine years of experience, Site 2)
>
> I don't like having to do an assessment where I don't feel I've had time to understand – to read the notes or to get information. So, I don't like sort of being rushed into an assessment or a decision, I don't like – so, that is a challenge for me because sometimes that is the case. (Pamela a white female AMHP and former ASW with 18 years of experience, Site 2)

The above extracts indicate that the AMHPs have very little time to understand the presenting issues and the risks of the person under assessment. This could then affect the AMHPs' detention decisions and consequently, impact the service user.

Reflecting on the observational data, there is evidence that organisational factors such as data monitoring and the risk of practitioners being blamed for risk management failures are significant influences on AMHPs' decision-making. Risk management practices such as case audits which present a way of holding AMHPs accountable for their performance are deemed to shape practice. This supports Calnan and Brown's (2013) assertion that organisational factors play a pivotal role in influencing professional conduct. Accounts by professionals of people losing their jobs and livelihoods for not adhering to risk management measures and organisational procedures put added pressure on AMHPs, and implications for their decision-making:

> I noticed ‘Mental Health Act Office’ written on the notice board and asked the trainee AMHP (social worker from the recovery team) what it was. She explained to me that MHA office deal with paperwork and see to it that all the due processes have been followed by the AMHP. She said, “people have lost their jobs for making mistakes or not complying with the procedures and standards, so the MHA office is there to provide oversight and to make sure that due processes are adhered to, and all the necessary documentation have been signed”. (Fieldnote 2, Week 2, Site1)

These organisational factors fuel defensive practices due to the fear of being held accountable for future bad outcomes (Davies, 2012). Whilst some AMHPs tolerated practising defensively and engaging in risk-averse practices, others such as George – a Black male AMHP with ten years of experience - appeared creative and more critical in their reflections on balancing compliance with risk management protocol and promoting the best interests of service users:

> The most challenging is the system whereby it’s got rigid in terms of… erm, protocol and law these days. Whereby - I will give you a typical example - whereby I got 83-year-old lady who was detained on a Section, the ambulance couldn’t come. And then I end up with the police putting this lady in my car and take her on the ward, later on, to be found that I should have waited for the ambulance, I’m not allowed to take a patient who’s been detained under a Section in my car. There is risk, in case like somebody pointed out during the conveying to hospital, if something happened to that patient it would be my responsibility. That is some of the things that I find quite frustrating because really at the end of the day, I’m acting in the best interest of the service user. Whatever I will do will be in the best interest, so those are the things that I can find frustrating.

The AMHPs recognise that the time spent with service users building trust and establishing relationships is vital for advancing understanding and knowledge of the individual and the social circumstances playing an important role when managing risk. However, high caseloads and audits are seen as obstacles:

> I think that [time] is one big thing, time is of the essence, and it’s very hard to spend time [with service users] because you are seeing one after the other, or you’re seeing one and heading out to see someone else in the community. That

> is one of the resources as well, time that you don't have. (Anna, a Black female trainee AMHP, Site 1)

During my observation of team duty, George - a Black male AMHP with ten years of experience - discussed a tragic incident involving a service user who committed suicide. His conversation with colleagues highlighted the detrimental impact of bureaucratic constraints and risk management practices, which often hinder practitioners from being available to service users when they are most in need:

> George said he would advise him to go to the crisis café or walk to the park and "that is how I manage the patient's risk". He added that when he left the trust, after three months, the person jumped from the sixth floor (through the window) and killed himself. He said he felt strongly that this person might have tried unsuccessfully to speak with someone over the phone before killing himself. Understandably, George appeared rather despondent when talking about this tragic incident. (Fieldnote 2, Week 2, Site 1)

These sentiments were echoed by Black service users who felt that professionals did not have time to build a relationship with them or even listen and pay attention to their needs due to their requirement to meet targets. This could affect trust, the service user's cooperation with professionals, and future access to the support services necessary for mitigating these risks:

> Ken (a Black service user, Site 1): I think that their care is very lean and minimalistic. They do what is necessary, but they don't do what can make healing occur. They don't go beyond what they …they focus on their KPIs.
>
> Interviewer: What is KPI?
>
> Ken: Their key performance index. They focus on, you know, their targets, more than doing what is beyond or what is necessary. Like just to listen, you know? They don't have the time for it or the scope for it, or they don't show that they wanna give anything extra that will benefit the patient.

It is noted that time spent with service users building relationships is essential for minimising risk, but paradoxically, the bureaucracy's emphasis on risk management affected this.

The efficacy of risk management mechanisms including pharmacological interventions is dependent on a service user’s cooperation. However, managerialism and the orientation of mental health services towards control and risk interventions such as involuntary admission appear to hinder concordance - such that a perceived restriction on a person’s independence will spur them to recapture the affected freedom, thereby resulting in non-cooperation (Maidment *et al.*, 2011) as demonstrated below:

> I had a very bad, uh, ECG result. So, they were gonna change my medication. But instead of letting me have influence like what you're talking about, having a discussion, they did - they took that away from me and said that by force they're going to inject me with the [medication]. So, whether I like it or not – so, they were gonna call the team for me immediately to restrain me, and then I reacted and then, that became an incident on the ward. But if I had a better relationship with them, it would have been a discussion rather than an incident. But it’s that forceful nature that they have, and the fact that they see - they think you are aggressive so they always outnumber you, and that can cause a - how can I put it? - can cause a fight or flight in you because you are cornered. (Ken, a Black service user, Site 1)

The orientation of services towards control rather than care and strategies employed in practice to reduce calculated risks could ironically exacerbate service users’ vulnerability and place them at risk:

> The AMHP asked her if she would consider further hospital admission, but she refused and also said that she would not take medication for mental illness as it does not help her. She appears very emotional and tearful while speaking through the staff interpreter. The patient did not believe she had mental health problems… [She was fidgeting and tapping her left foot whilst talking, appearing anxious and somewhat worried]. The AMHP said to her that they would go to have discussion about what should happen next. Right after the AMHP mentioned this to her, she looked at the interpreter and said, “I will hang myself if people force me to do things”. I felt like she knew that the practitioners would make a decision to detain her further in hospital against her will, so wanted them to know what she could do if they force her to stay in hospital and take mental health medication. (Fieldnote 20, Week 22, Site 1)

The data demonstrates that client relationships were negatively affected by professionals’ risk-averse practices derived from managerial culture or fear of making a mistake, service users’ previous experiences of detention, and AMHPs’ risk decisions, all creating suspicion, mistrust, and non-engagement (Brown and Gale, 2018). This was evident during my observation of an MHA assessment in a hospital setting involving AMHP George, the Section 12 independent doctor, a student mental health nurse, and a ward nurse providing one-to-one support for the patient:

> On arrival, the AMHP and the doctor showed their ID cards to the patient while trying to introduce themselves, but the patient appeared very suspicious, [grimaced] and said, “I only speak with my GP and consultant. I don’t know you so go away. I don’t want to hear anything from you, go away” [followed by hand gestures suggestive of telling the practitioners to leave]. The patient looked at her 1:1 worker and said, “I don’t want any help from anyone because nothing is wrong with me. I am feeling very well…” She looked at her 1:1 worker saying, “I know I’m not going home so I don’t want to talk to anyone”. She takes a glass filled with water from her bedside to sip and refuses to talk or look at the professionals. The doctor looks at the AMHP, appearing a bit dejected as the patient refuses to answer questions. (Fieldnote 21, Week 22, Site1)

The service user’s account suggests that she did not trust the assessing team, perhaps due to previous experience of risk intervention, and her lack of prior relationship with the professionals. She felt that the practitioners had already decided on her continuous involuntary admission and that her choices or preferences did not matter. She believed that whatever she said would not be taken into account, hence her non-cooperation.

These tensions were less apparent within the accounts of AMHPs from Black backgrounds who reported that Black service users tended to identify and cooperate with them better due to their shared social identity, as Venus – a Black female AMHP with five years of experience - explained:

> So, that's one example where things can be difficult, where there is that mistrust and they don't cooperate. And then, on the other side, being an ethnic minority myself, whereby people in some cases - that they will trust me - they will see me as family.

The differing perspectives and experiences of AMHPs and service users corroborate the reported tensions emanating from face-to-face risk work, with risk management and procedural protocol-driven practices for minimising risk paradoxically creating mistrust in service users, damaging cooperation and placing them at risk due to practitioners' defensive approaches and interventions (Spendlove, 2018).

5.6 The myth of AMHP autonomy

5.6.1 Fear of accountability

According to Section 13 of the MHA, AMHPs must exercise their own independent decisions (DoH, 2015) as to whether to make a detention application subject to several factors - including medical and social evidence - outside of the dictate of their employers or other professionals from the multi-agency team, such as the doctors (Brown, 2016). AMHPs – the majority of which are social workers - are expected to have the skills and knowledge to recognise and challenge a behaviour or aspect of the law discriminating against particular social groups or people from Black backgrounds who encounter social disadvantages (Campbell, 2010). However, when talking with AMHPs about the complexities of discharging their role, most cast doubts on their ability to exercise an independent decision within the context of multiagency working, organisational factors, resource implications, and 'blame culture'. The AMHPs in this study found it challenging to defy two medical recommendations for fear of being blamed for bad outcomes or potential future risks of harm. Lacking the confidence to trust their judgements, some of the AMHPs saw themselves as part of the mental health system, with detention decision-making a collective endeavour rather than the work of a single professional exercising their discretionary power:

> I was having this conversation the other day about assessing risk. And about how as a practitioner, to go against two medical recommendations - you're really going out on a limb. Because if something happens and shit hits the fan, it's going to be you explaining. "Well, you had two medical recommendations, two doctors, two medical professionals said that this person needed to be detained and why didn't you?" Erm, so, I think that we – I think as AMHPs, we talk about being autonomous but we're probably more part of the system and entrenched in making – trying to – it's rare that we are able to make autonomous decisions. (Bridget, a white female AMHP with eight years of experience, Site 2)

Theoretically, the code of practice and legislation directs AMHPs to make autonomous decisions incorporating social perspectives into their judgements (DoH, 2015) by working to promote positive risk-taking, relationship-based practice, user participation, and right-based interventions to resolve the social determinants of mental health problems. However, what occurs in practice paints a different picture. From a legal consciousness perspective, there is a gulf between AMHPs' grasp of the law in books and action (Silbey, 2005); this concerns how practitioners understand, experience, and act as to the law relative to practice realities. As shown in the following extract, the AMHP finds risk work problematic in situations requiring assertiveness or obligating her to formulate the independent decisions required by law and the code of practice within a context dominated by the medical model:

> There are challenges where you have to be assertive and make your own decisions and not try to be influenced by doctors. (Vivian, a Black female AMHP with one year of experience, Site 1)

In such situations, it is highly difficult for practitioners to maintain independence, especially when other professionals within the team hold pre-determined positions regarding what should happen. Mary - an AMHP with twelve years of practice experience (Site 1) - gave a poignant account of the pressure she faced from other workers within the assessment team who not only hindered her attempts to make independent decisions but also sought to convince her she was misguided. This prevents positive risk-taking, and engenders more precautionary practice from professionals (Warner, 2007):

> I find it most challenging if my colleagues are not prepared to be objective, to understand why you are making the decisions you are making, or they try to convince you that you are wrong. They go against the practice of letting you make the decision because every assessment that an AMHP does is the AMHP's decision. The local authority director cannot come to tell me to say we should have admitted this person and should not have admitted this one. Why? They are not trained to do that; I was trained to do that. And what every AMHP should do is to look at the law, how it affects the person. How [do] you make your decision under the law? Look at every aspect of it. (Mary, a Black female AMHP with twelve years of experience, Site 1)

Here, the AMHP is aware that she is trained to discharge a specific function as required by law, and that her decisions can profoundly impact the individual assessed under the MHA. Mary makes a clear distinction between unqualified opinion and her professional risk knowledge acquired through training, affording her a degree of power and status. She believes that her professional judgement, operating in tandem with this specialised knowledge from her 'training', legitimises her decision. I concur with Mary that an AMHP's specific training coupled with their legal mandate to determine detention decisions should enable them to operate independently, however, the data illustrates that in reality, the working environment does not promote autonomous AMHP decision-making.

The observational data demonstrates that fear of accountability drives detention decisions by AMHPs (Coffey *et al.*, 2017):

> During observation of team duty, Kevin – a Black male AMHP Lead with ten years of practice experience - talked about responsibility, power, and associated accountability. He stated that "we have so much power but whatever happens after your decision is on your head…" He also said that "the MHA is too medicalised, so when you disagree with the medical recommendation and something goes wrong, your head is on the line". He [the AMHP Lead] sounded as though he is always conscious about the consequences of his decisions, which made me wonder if he is likely to engage in defensive practice to avoid being blamed for bad outcomes. (Fieldnotes 2, Week 2, Site 1)

This suggests that the medical model - focused on symptoms and compliance with medication - reinforces risk-aversion strategies proven to lead to admission, while positive risk-taking - leading to less restrictive options - remains the domain of AMHPs. However, the majority of AMHPs alluded to avoiding potential future uncertainty and the fear of accountability for bad outcomes regarding detention decisions by engaging in risk-averse practices, consequently feeding the dominant biomedical model. This is less demanding on professionals/decision-makers but will not be in the service users' interests.

The following quote describes the pressure on AMHPs to be cautious of resisting medical recommendations. It also suggests that professionals are wary of adverse consequences, given their level of discretion and independence over detention decisions enshrined by the MHA. AMHPs risk being held personally accountable for their practice (Golightley 2014) when making a decision dissenting from medical opinion. It is noted that a practitioner's ability to exercise autonomous decision-making alongside their responsibility to practically utilise the social model is dependent on their level of experience and skills. However, the data reveals that many AMHPs, including experienced practitioners, adopt precautionary or defensive approaches by making their decisions harmonious with the medical perspective. This supports prior evidence of social workers relying on orthodox medical narratives and the accompanying risk language (Campbell, 2010) for detention decisions rather than relying on their skills and knowledge:

> As an AMHP you always have the autonomy, but because of the fact that there's a lot of litigation, you know, there's always the risk that you are dealing with, you can't always rely on your autonomy to prevail. When you do an assessment and you have the doctor's perspective - two doctor's perspectives - but you are of the opinion that this patient would do well with the least restrictive option, you are now pushed by two medical professionals against your view, so that's where the challenge comes. So, it depends on your experience, your level of practice, how you are able to make a decision based on, you know, what you're faced with. But many AMHPs will just bend towards the medical recommendation and then have their autonomy sort of taken away or compromised. (Kevin, a Black male AMHP Lead with eleven years of practice experience, Site 1)

Notionally, AMHPs should be “independent arbiters” standing up for service user rights, maintaining an independent perspective counterbalancing and challenging the medical model. Consequently, AMHP autonomy is often assessed in terms of their readiness to take risks in the face of a medical professional’s reluctance to do so. However, the AMHPs described diminished professional autonomy due to the level of uncertainty in risk work and their fear of being blamed for negative outcomes, displaying defensiveness over their risk knowledge and affecting both their practice and mandate for independent decision-making. Amber, a Black female AMHP with ten years of experience (Site 2) explained:

> Although you're questioning, “oh, can we do something different? Does this really need to happen?” Both doctors are saying “yes”. The care coordinator is saying “yes”. So, I think on one hand, on paper, it gives the impression - this illusion of independence, but I struggle with – unless I can get as many people on board with the plan, I struggle with holding the risk all by myself… and if something happens, all the doctors, everybody will say, “Well, we did our part”.

This AMHP’s frustration at the lack of positive risk-taking is supported by the observational data showing a culture of AMHPs struggling with the risk management aspects of their work and constantly wary of personal liability, ultimately impacting their autonomous decision-making. Several AMHPs felt comfortable sharing risk decisions with medical professionals out of fear of accountability:

> While talking with Vivian [an AMHP with one year of experience] about the nature of their work and what she does when on duty, she commented that “our work is essentially about MHA assessment and managing risk”. She added, “the AMHP role can be very tricky and dangerous at times, so you always have to be mindful and share the risks with other professionals”. (Fieldnote 4, Week 4, Site 1)

Here, the practitioner alludes to collective responsibility should something go wrong; suggesting that their construction of risk factors may be dependent upon the perception of other professionals within the multi-agency team. By sharing decision-making, the AMHP could avoid ploughing their furrow. However, this could impact positive risk-taking and lead to negative implications for service users.

Doctors and clinicians continue to wield considerable power within the multi-disciplinary setting, given the prevalence of risk and the medical model driving defensive practice:

> During the observation of team duty, I asked George [a Black male AMHP of with ten years of experience] a question to seek clarity about the discussion he was having with his manager. I wanted to know what may happen or what may be the implication if he disagrees with the two doctors’ recommendations. George gave a striking response that although [AMHPs] have the ultimate decision-making responsibility in terms of making an application for detention, if “I decide to go against two doctors’ recommendation I stand on my own and run the risk of personal liability should anything bad happen”. (Fieldnote 1, Week 1, Site 1)

This account is consistent with the findings of earlier studies about professionals’ fear of accountability and their tendency to engage in risk-averse and defensive practices (Fistein *et al.*, 2016).

Whilst the majority of the AMHPs acknowledge that it is rare for them to exercise an independent decision within a working environment dominated by the biomedical model, others with more practice experience noted that AMHPs could challenge medical recommendations or make independent decisions contingent upon practice wisdom, confidence, and assertiveness. A conversation with George – a Black practitioner with ten years of experience as an AMHP (Site 1) - suggested that more experienced workers can be more assertive when negotiating with the doctors, as they can better exercise their legally determined discretionary authority over whether to detain a patient than their inexperienced colleagues:

> I mean that comes with a lot of experience, with confidence as well. When you are newly qualified as an AMHP… erm, you could be very shy. These people could be very overpowering because of their medical background but with experience, you have to be able to assert yourself, and be assertive really, and make sure that your view is heard and have that discussion with them. And that’s one of the reasons I will remind the doctor at the end of the day I’m the one who is making the application. You may make the two medical recommendations but I’m the one who is making the decision to detain the patient.

5.6.2 Impact of resources on AMHPs’ decisions

An AMHP’s ability to exercise independent decision-making to champion the least restrictive option for a client is likewise linked to the availability of resources. Having practised as an ASW and AMHP for 30 years, Denise (a white female) suggested that while she possessed the confidence and experience to stand her ground and not be dictated to by medical professionals, the nature of service provision, limited resources, and lack of support in the community all affected her independent decision making:

> I'm very experienced, I'm very confident and comfortable in my role, so I have no issue with, for example, not sharing the same perspective as another member of the assessing team or indeed other partners to an assessment, for example, liaison psychiatry. However, I do think that the way that services are organised at the moment does put additional pressure on my ability to act as independently and to be able to access the resources that I think people should

> have in order to recover from an acute mental health crisis. (Denise, a white ASW and AMHP with 30 years of experience)

This statement concurs with previous evidence demonstrating how a lack of alternative resources hinders AMHP practice (Kinney, 2009) and their requirement to make independent decisions. This AMHP's account highlights that while she may disagree with the doctors, organisational factors not only affect her ability to make autonomous decisions but also coordinate the resources necessary for keeping a person within the community.

To make an informed and autonomous decision, AMHPs also require ample time to explore social support networks, alternative means, and community services. However, due to organisational demand to meet deadlines within a busy working environment, professionals are hamstrung by limited time:

> We will spend more time trying to explore the support network, trying to see what resources in the community - we will spend more time doing that but unfortunately, sometimes we do not have the time to do that because when you've got somebody on 136, for example, and the clock is ticking and they need to be assessed within a certain time, you don't have that time maybe to look around, leave a message, wait for somebody to call back. That's what we are faced with really. (George, an AMHP with ten years of experience, Site 1)

Professionals acknowledge that lack of resources has become a systemic issue to the extent that service users cannot access the support they need to mitigate crises and prevent detention. This absence of power and control over resources and alternatives to detention impacts the AMHP role through their interpretation of risk and independent decisions. Whilst observing team duty at Site 1, Yasmin – a Black female AMHP of six years - and Kevin, (a Black male) the team manager, discussed the issues normally encountered by service users and their nearest relatives. The team manager commented, "the fact the AMHPs tend to be involved when the patients are in their lowest point, we get the brunt of the families and nearest relatives especially when they feel that the system has failed them by not getting early intervention support in the community".

This suggests that limited resources and systemic failure negatively affect the AMHPs' everyday experience of 'risk work', particularly the social relation component that centres relationships and interactions at the heart of a professional's experience (Brown and Gale, 2018). Lack of resources impacts professionals' risk interventions and detention decisions, potentially adversely affecting client relationships leading to mistrust and lack of engagement. Consequently, this undermines a professional's ability to understand the risks concerning an individual or a particular social group (Heyman *et al.*, 2013; Brown and Gale, 2018). Kevin succinctly captures the tension that can arise between social relations and risk intervention: "You do not want to fall out with the nearest relatives as they can sometimes raise unreasonable objection to your application".

The observational data revealed that in conjunction with inadequate resources shaping independent decision-making and the day-to-day experience of risk work, it also creates a "revolving door syndrome":

> Admittedly, Kevin said sometimes patients do not get the best support until they are detained. He said that "the system is so flawed because of resource constraint. Bed shortage leads to some patients being discharged too early, only to be readmitted later". (Fieldnote 2, Week 2, Site 1)

Professionals also talked openly about how insufficient resources are endemic across all local authorities, influencing AMHPs' supposedly independent detention decisions:

> Yasmin stated that "resources are a huge issue in every LA, and sometimes you have to say no to people not because you want to, but it's because there are no resources with which to help them". Yasmin said in a rather low tone and

> sounded sympathetic towards the patients - who are at the receiving end of this resource problem. (Fieldnote 2, Week 2, Site 1)

5.7 Conclusion

In summary, this chapter has demonstrated a reciprocal relationship between risk and ethnicity in detention decision-making. It has illustrated racialised categorisations of risk, and how AMHP decision-making continues to be shaped by risk or public safety agendas. Notably, the risks to self and the iatrogenic effects of compulsory detention for Black people were often marginalised in professionals' knowledge formulation and decision-making processes. Black service users appeared to be predominantly viewed through a narrow lens focused on their diagnosis and perceived risk to the public. Their social realities, life contexts, and the complexities of their individual preferences and experiences were often disregarded, resulting in epistemic injustice. The findings reveal professional anxiety and uncertainty over the potential for Black service users to do something harmful in the community and the need to prevent this by imposing restrictions on their liberty, both inside and outside the confines of the hospital. This section also illustrated AMHPs' general approach to risk-based decision-making about Black service users in the community, classifying and conceptualising risk through Black parents' decisions to initiate an MHA referral or report their male child to the law enforcement given what we know about Black service users' experiences of police brutality. The findings also established how AMHPs experience risk work problematically, showing a bureaucratic emphasis on risk management strategies designed to improve safety paradoxically affecting the relationship-based practice seen as necessary for reducing risk. Finally, these findings disclosed that AMHPs were frequently confronted with the challenge of achieving social perspective goals within the context of the dominant legal/biomedical model, multiagency working, organisational factors, resource implications, and ‘blame culture’. In the following findings chapter, I present the data and analysis of the specific issues relating to whether professionals consider the knowledge, circumstances, and experiences of service users when forming their judgements about detention.

Chapter 6: Epistemic injustice

6.1 Introduction

This chapter presents and analyses data illustrating epistemic injustice within the MHA assessment process. This chapter presents and analyses data illustrating the second key concept, namely epistemic injustice. This chapter is organised under the five main themes of epistemic privilege, limited epistemic agency, testimonial injustice, epistemic exclusion, and enhancing epistemic justice. While presented in a linear format, these themes are interrelated and iterative in practice. The first four reveal that various forms of epistemic injustices were common in participants' accounts. It was evident from these that MHA assessments were characterised by unequal power dynamics privileging certain types of knowledge, with some participants describing how their experiences and understanding were downgraded or disregarded. Drawing on data from observations and field interviews, my analysis argues that although the themes presented in this chapter share a common conceptual core with epistemic injustice - degrading or discounting certain people’s knowledge, assertions, or interpretations – how such injustice manifests can differ considerably, ranging from the direct and blatant to the more subtly nuanced. By presenting and analysing data to illustrate the various distinctive forms of epistemic practices and injustices, this chapter offers insight into Black service users' perspectives of their detention experiences and their level of involvement or participation in decisions about their care and treatment, while addressing the research question: *what account do professionals take of the knowledge, circumstances, and experiences of service users?* The chapter also discusses an important element of participants' accounts concerning the numerous ways of enhancing epistemic justice, including the facilitative role played by mental health advocates to lessening the wrongs generated by the dominance of risk in MHA assessments.

6.2 Epistemic privilege

Participants' accounts indicate that epistemic injustice stems from the comparative epistemic privilege of certain professionals involved in the assessment process. The data reveals that practitioners possess this status through their training, expertise, and objective data, to "occupy the epistemically privileged role" (Carel and Kidd, 2014, p.16) of assessing risk and making judgements over which testimony or risk knowledge is worthy of epistemic consideration. This was evident within a discussion in practice between Bridget – a white female AMHP with eight years of experience - and Dr L - a Section 12 approved doctor - during the MHA assessment of Finn - a Black service user at Site 2 – whose 28-day detention under Section 2 was coming to an end. The assessment was for deciding whether the service user's involuntary admission should be extended under Section 3 of the MHA, potentially up to six months:

> Dr L concluded that the patient's best interest is to stay longer in hospital. Bridget agreed with Dr L's recommendation for Finn to remain in hospital under Section 3. She also commented that the ward is a provocative environment, and the more Finn reacts to other patients' behaviour the less likely he is to be "stepped down". Bridget said, "personally it's not practicable to consult with the nearest relative because they have got their own mental illness going on and the mother can't make decisions around this because previously, she objected to the decision to detain her older son who also suffers from mental disorder". Bridget added that the "mother doesn't clearly understand what the needs are and that if she objects or decides to discharge the patient, that will be blocked on the level of dangerousness". (Fieldnote 4, Week 2, Site 2)

Bridget suggests that because the mother also suffers from mental health issues, she "doesn't clearly understand what the needs are". This AMHP implies that the mother's opinion should be disregarded because she lacks the necessary competency to be given attention. This extract reveals that as decision-makers, professionals become "epistemically privileged", occupying an authoritative role in an epistemic exchange while holding the power to decide which testimonies to consider, and whether the views or choices of the closest relatives/carers matter when determining whether to extend a service user's compulsory admission. The AMHP seems to defer to biomedical knowledge, dismissing the carer's perspective.

A conversation with Kevin, a Black male AMHP Lead at Site 1, during my observation of team duty also reflected the power imbalance within the mental health system privileging professional authority over the testimonies of service users and carers:

> Kevin appeared relaxed and eager to share a lot of information regarding his experience and practice encounter with patients and carers with me. He said that when a nearest relative (NR) objects without giving any reasonable grounds, " [AMHPs] will tell them that if they object, their relative is still going to be in hospital under Section 2 until we apply to court and get authorisation for displacement". He recounted that in one of his previous cases concerning a female patient from Afghanistan, her mother was objecting to detention under Section 3 despite the patient being very unwell. He eventually applied to displace the mother, describing the NR as "not having any insight into the risks or concerns that the professionals have raised". (Fieldnote 2, Week 4, Site 1)

Bridget, a white female AMHP with eight years of experience, described how during an epistemic exchange, their responsibility as a decision-maker and their legal mandate to conduct MHA assessments privileged AMHPs:

> We're never going to be on an equal footing if I'm coming to see you under the Mental Health Act, I'm still going to tell you how it goes at the end of it potentially if we're going to detain you.

The AMHP describes holding the power to detain the person under assessment. The service user expects the outcome of the risk assessment to be communicated by the AMPH, but the AMHP does not expect to be told by the service user what the outcome should be. Consequently, there is a power imbalance in the AMHP and service user relationship due to the hierarchy ascribing the professional an elevated epistemic status and widely recognised social position. (Carel and Kidd, 2014)

Professionals and service users can be "epistemically privileged" for a variety of reasons; however, during the risk assessment and decisions relating to detention, only the professional's privileged status matters. A service user's knowledge is commonly restricted to the "private realm" (Carel and Kidd, 2014, p.16) and is omitted from detention decisions, risk interventions, and treatment plans. Participants described how professional knowledge - particularly from a consultant - is privileged over the views and wishes of service users and their families, absenting professional scrutiny of the risks of detention from the process. A comment by George – a Black male AMHP with ten years of experience - following a conversation with a senior manager regarding her decision to privilege a consultant's position over a close relative reflected this:

> She [the senior manager] never challenges anything that comes from the top… if everything that the consultant says is right, what power has the nearest relative got? (Fieldnote 15, Week 13, Site1)

Implicitly, a consultant's expertise is never interrogated because of their epistemic authority to judge risk. A professional's ability to produce and advance risk knowledge is accorded an inflated level of credibility, to the detriment of the non-expert service user/nearest relative who receives lower epistemic authority due to prejudice. The observational data reflects how epistemic privilege is a more subtle form of epistemic injustice related to the disparity between service user and professional perspectives of mental illness or risk.

6.3 Limited epistemic agency

The process of the MHA assessment, unequal power dynamics, and the relational aspects of detention appear to limit service users' epistemic agency. Bridget captures this succinctly in the following comment:

> We hold significant power when we see people, but how do you make things better, you know? How do you work around the power differential? 'Cos you're never going to eliminate it because you do have the power to make an application, (Bridget, a white female AMHP with eight years of experience, Site 2)

Participants described how professional power manifests in practice, with the presence of large numbers of professionals - including police officers - overwhelming service users and silencing their experiences:

> Interviewer: So, what you are saying is that the presence of many professionals and police officers can actually make somebody become silent and not wanting to talk about their situation?
>
> Respondent: Yes, too many professionals can intimidate the patient. You are the only one there. You may have your family there, but you know your family may not even know… information is power - knowledge is power. (Mary, a Black female AMHP with twelve years of experience, Site 1)

According to Mary, service users were disempowered by the sheer number of professionals during the MHA assessment process, limiting their ability to articulate their views or openly share information:

> It is intimidating. He cannot express himself. What voice would that person have among everybody? In fact, it would be intimidating and that's why he would not answer questions for me to draw out information from him or see how he is doing (Mary, a Black female AMHP with twelve years of experience, Site 1)

Participants referred to instances of coercion, physical restraint, and unpleasant, "crude ways" of administering medication during hospital detention, with service users' experiences of inhumane and punitive conduct discouraging them from speaking up. Venus, a Black female AMHP with five years of experience, provides a vivid description of the hospital environment that encapsulates the response to a service user refusing medication:

> In hospital, [medication] can be administered in a compulsory way… if they refuse oral tablets, then they can have IM injection and the injection is not pleasant… They can be used [in a] crude way… They can be pinned down and be given – restrained, and the restraining is not pleasant. It's not pleasant. You have people holding your legs, your limbs, everywhere, and they're injecting you. If people are holding you, obviously it's tense, your body is tense, and they're sticking a needle into you. It's not pleasant at all. So, most service users, they are aware that if they refuse, they will be restrained and they'll get an injection, which is not a pleasant experience. So, they would comply.

It is significant that while both white and Black patients are subject to pharmacological restraints and other medication-related issues - as previously discussed in Section 5.5.5, page 152 - the data indicates that Black service users are disproportionately affected and are more likely to be offered higher doses of anti-psychotics. This reflects a broader pattern of systemic mistreatment that Black service users disproportionately experience within mental health services, as highlighted in the literature (Fernando, 2017).

Experiences of restraint and punitive interventions and treatments given to service users - particularly those from Black communities - serve to check their epistemic agency, creating considerable fear and mistrust of services (Keating and Robinson, 2004).

Service users reported that involuntary admission limited their ability to exercise their rights or articulate wishes and concerns. For some service users, prior experiences of unsuccessful appeals and disempowerment by professionals overlooking their complaints and failing to consider their views or choices undermined their willingness and capacity to challenge subsequent decisions they perceived as unfair:

> Despite the patient saying clearly that he won't appeal his detention again, the AMHP advised him yet again to contact his solicitor to appeal his detention, explaining to him that the longer he stays, the more provoking it's going to be. Finn [a Black service user] responded that while on the ward, he's been deprived of his mobile phone so he cannot speak with anyone. He does not have any money on him so the place is not good for him, but his appeal will achieve nothing as he has already done it before with no success. He said, "My opinion and choices do not matter, so there is no need to appeal the decision". (Fieldnote 4, Week 2, Site 2).

This pessimism from service users reflects their lack of autonomy and limited epistemic agency regarding decisions about their care and treatment, as further described by Thomas, a Black service user at Site 1:

> They came to me, and they just basically said that you will have to come to the hospital. So, I had to understand I had to just go, I just had to go with it. There was no – I couldn't say no because it was just a process, isn't it? You know what I'm saying that I had to go with them, isn't it? I didn't have any choice.

Thomas intimates that he does not rate his chances of challenging a practitioner's decision and so chose compliance, ultimately resulting in his knowledge being discounted and concealed by professional knowledge. There is evidence that a professional's authoritative status and legally-sanctioned decision-making powers negated service user epistemic agency (Newbigging and Ridley, 2018). Furthermore, Thomas has accepted his powerlessness position, believing it to be “just the process” for the professionals to dictate his treatment without considering his preferences or choices. This account underscores the lack of autonomy in the decision-making process, where the service user is resigned to the situation without the ability to voice an alternative perspective or refuse treatment.

While Thomas was very aware of the undesirability of being deprived of his liberty, he sensed that the detention experience impacted his epistemic agency and capacity to exercise his rights:

> It’s not good for someone to take away your freedom, innit? And like you don’t have any rights or anything like that or you can’t do anything about it. You’re going by their terms.

There was a feeling among service users that professionals held obscure agendas, with no opportunity to challenge professionals’ decisions or the assumptions made about them:

> You just have people that will say to you from the get-go, “I know what’s going to happen here today, there’s no point in me talking because you’ve already made up your mind”. (Bridget, an experienced white female AMHP of eight years)

Finn - a Black service user at Site 2 - supported this, seeing little reason to challenge his detention because his views, experience, and anecdotal accounts did not matter, and so he lacked motivation to “fight a losing battle”:

> I've sat there in the hall meeting and everything the consultants and nurses - especially the nurse that will be sitting with me - they will just tell so many lies about me. They will start making up things on the spot. They'll make up things that never happened, and it's like what can we do as a patient? Like we have no powers… and they are going to deliver what they say is the facts when it's not always the facts. It's just like, what's the point? You are just trying to fight a losing battle sometimes… Like there are many things that I've had to do in the

> past where I've had to let staff and consultants - and certain people - say what they want to say just to be able to get back outside and get back to my life.

Even though a small number of service users discussed the feelings of safety and security provided by hospital admission, the most common account participants articulated about detention was that it was inhumane, disabling, terrifying, and disempowering. It is difficult to find one's voice in a punitive environment described as worse than serving a prison sentence:

> …there are many situations I've been in where I've even told police, "don't take me to hospital. Can I just go to prison for whatever it is I've done wrong? …Don't take me to hospital". And they will still take me to hospital, and then it just makes things worse for me… You are treated more like a human in prison to be very honest. They may look at you like a scumbag as well, but they treat you like a human being. (Finn, a Black service user at Site 2)

In this recounted experience, the service user is subjected to detention without any specific hearing, meaning they don't have to go to court and don't have to present evidence. Placed somewhere he considers worse than prison and subjected to medication that he does not want, there is nothing he can do about it. Rendered extremely vulnerable and with limited epistemic agency, this form of injustice dehumanises him.

The processes of MHA assessment and detention limit service users' epistemic agency, impacting their participation and ability to exercise their rights, especially for Black and ethnic minority people with language barriers requiring translation services. The observational data presents that a shortage of interpreters limits a person's ability to engage with the assessment process, understand the information shared by professionals during the MHA assessments, and articulate their experiences and preferences.

A particularly striking example of how the MHA assessment process constrains epistemic agency and impedes service user participation emerged during my observation of an MHA assessment deciding whether a service user should remain in the hospital under Section 3. During the exchange between the doctor, AMHP, and service user, it was clear that not having access to an interpreter impacted the service user's epistemic agency, and presumably the detention decision:

> The service user arrived a few minutes later, sat closer to the doctor (who is of an Asian descent) and said to him, "you are a Pakistani, are you here to translate the conversation to me?" The service user then started to speak Urdu hoping that the doctor would communicate with her in that dialect. Using a calm tone, the doctor mentioned his name (which sounded like an Indian name) and said to the service user that he was an independent psychiatrist and will only speak English for the purpose of the assessment. The service user sat down, slouching into her chair, with her eyes down, appearing unhappy. The doctor tried to explain to her that he understands the language, but he cannot speak it. He added that the purpose of the meeting was to assess her mental health needs, so it was better to speak English. As the doctor was still talking to the service user, she looks up, puts her palms together and says, "I am praying". Everyone appears silent and looks at the patient. She puts her hands on her lap and looks at Dr P. The doctor asked the service user if she wanted to stay in hospital for a few more weeks for her treatment, but she answered, "no, I want to leave now…" The service user tried again to speak to the doctor in Urdu… saying that she is more comfortable engaging in the assessment in her native language. (Fieldnote 4, Week 5, Site 1)

The doctor and AMHP decided to further detain the service user under Section 3 without allowing for her meaningful participation in this epistemic activity, neither questioning whether using an interpreter might have benefited the service user to better understand the assessment process or articulate her views and preferences. Following the assessment, I talked to the AMHP about the service user trying to speak with the doctor in Urdu, and whether she thought using an interpreter would have helped. The AMHP was uncomfortable with this question, looking away while admitting that having someone speaking the service user's preferred language would have helped, although it would have been unlikely to influence the outcome. She was quick to add that on some occasions, using an interpreter with a service user possessing limited English might influence the outcome of the assessment, “but on this occasion, no”.

Arguably, the reason professionals did not offer the service user an interpreter for such a crucial assessment was partly due to the service user being seen by the professionals as an object of their investigation (Scrutton, 2017) or risk assessment rather than as a subject of possible knowledge requiring consideration.

6.4 Testimonial injustice

Testimonial injustice occurs when a person’s testimony or experience is assigned lesser or greater credibility as a consequence of prejudice towards their social identity, such as race, gender, accent, or mental illness (Fricker, 2007). Participants described how service users’ accounts were discounted or dismissed because of their mental illness and social background, with Ana - a Black female trainee AMHP at Site 1 - reflecting:

> I remember another guy [Adu], he’s Ghanaian actually, and he kept saying… he’s a prince from his own country and of course… it was a bit tangential, but he was saying, “I don’t need to bow down to the Queen, because I’m a prince from where I come from”. They didn’t believe that, but I said, “actually hang on a minute, do you know that in African countries people do have this kind of royalties and hierarchies in their own tribes”. So, later on… after he’d become quite well, and actually he came to my team… we found out that genuinely he was from his own kingdom, he was a prince. So, that was not a psychotic thing.

The Black service user, Adu, received lower credibility due to his race and having a mental health condition associated with delusion and irrationality. The professionals assessing him believed his testimony to most probably be an extension of his psychotic condition. The prejudice demonstrated in this extract occurred because of negative stereotypes associated with Adu's social and cultural identity, and consequently, they overlooked important information about his culture and identity which might have explained his presentation or behaviour at the time.

During an informal conversation with the AMHPs observing team duty, on hearing Ana's reflection on her work with Adu, George – a Black male AMHP with ten years of experience at Site 1 - reported his own experience of testimonial injustice:

> Venus [a Black female AMHP with five years of experience at Site 1] and I were talking about Ana's case where the patient had told professionals that he is a prince and comes from a royal family in his native country during an MHA assessment and professionals did not believe him, attributing what he was saying to a symptom of psychosis (delusional disorder), but later, it was found to be true. George heard our conversation and said, "why didn't they believe him?" [He pauses to reflect] "…we fall into that trap a lot - me too - I fall into it myself. You remember the lady that I said I saw at St G… she said she owns her flat, I didn't believe her… but when I was discussing with Yasmin… the following day she said, 'oh no, she owns her flat'. We fall into that trap a lot. We get blurred with the fact that the person is mentally unwell and sometimes these things happen… you see what I'm saying?" [light laughter from all of us] (Fieldnote 19, Week 18, Site 1)

This extract embodies epistemic injustice, whereby the service user's account is disbelieved. This participant candidly states that the service user's credibility is undeservedly disputed simply because of her mental illness. There was no prior evidence of this individual being unreliable in her testimony, yet she suffered a "credibility deficit" because she had a mental health condition.

The stigmatisations and the negative experiences people with mental health difficulties encounter in the community – including becoming victims of anti-social behaviours - may be disbelieved during the referral and assessment process. The data reveals that when service users make valid complaints or express reasonable concerns over issues they are facing with their neighbours or members of the public, their accounts are often ignored or dismissed as symptoms of their mental disorder. The following account from Bridget, a white female AMHP with eight years of experience at site 2, illustrates this:

> What happens is someone raises a legitimate concern and it will get written that they’re delusional, you know? Like we often get referrals for people who have issues with their neighbours, and they’ll say, “well like there’s nothing -” We know that people are horrible. And if you’ve got someone with a mental health problem living next door to you, who’s to say that you’re not smashing their windows? Who’s to say that they’re not being targeted by their neighbours because they’ve got mental health issues? But we always err on the side of caution and blame the person with mental health issues rather than probably exploring the anti-social behaviours of others.

Service user accounts - particularly those from Black communities – of not being heard or even offered the opportunity to articulate their preferences were often referenced:

> I personally think a lot of them just want to feel like they're being heard… so, it’s almost like you could disagree, you could ever attribute it to mental illness, but give them the opportunity to talk, and I feel like that's where a lot of the tension and unnecessary irritation - agitation often comes in an assessment. Because we go - the doctors have their list of questions, they're very clinical. They're very much aware of time. So, you have a client who wants to explain themselves or they are taking longer time, and then the doctors are trying to redirect them, cut them off, or do this and do that, and the person starts getting agitated. I feel that I often find that with ethnic minority people. (Amber, a Black female AMHP with ten years of experience, Site 2)

What is interesting about this extract is that despite Amber’s clear identification of the problem, she does not reference using her role of AMHP to challenge this doctor’s practice. Epistemic injustice occurs because one acquiesces with or fails to challenge “epistemically unjust structures” (Carel and Kidd, 2014). This also suggests a focus on managerial, protocol-driven practice and risk management pressures - such as excessive caseloads, time constraints, and case audits - undermining an AMHP’s social perspective, which should be rights-based and reflect the principles of empowerment and user participation (DoH, 2015).

Ken’s account - a Black service user at Site 1 - poignantly illustrates Fricker’s (2007) description of the “identity-prejudicial credibility deficit” whereby a person’s testimony is afforded lower integrity owing to preconceptions derived from their social identity:

> I didn't feel listened to… ’cause I was there for three years and they moved me from different wards. So, initially, I was with an Asian - an Asian clinician and when I was trying to explain to her the cultural difficulties that I experienced as a Black person, she didn't really show any compassion. She just isolated the incident to what happened with the police, and they only look at one side, which is the fact that I did hit a police person, but they didn't look at the side that I was tasered twice and that I was attacked by eight or nine of them. So, they didn't look at anything to do with defence or fear. They rather look at me as the aggressor - yeah. And I think it's because number one, stereotype, and number two, gender difference as well. I mean, if I was female, I will be looked at differently. If I was white, I will be looked at differently. But to be a Black male is a different ball game. (Ken, a Black service user - Site 1)

According to Ken, his report of being violently attacked by eight or nine police officers was afforded reduced credibility due to prejudices related to his social identity as being a “Black male”. He was unfairly discriminated against because his race and gender should be irrelevant in deciding whether he is a credible knower/testifier, and therefore, should not determine the level of credibility attributed to his testimony. Ken alluded that negative stereotypes of Black men as dangerous in particular, partly accounted for the clinician’s denigration of his experience and knowledge. Ken’s experience reinforces what it means to be a Black man; his account implies that the only credible story is that he is violent, with no space for him as a Black man to describe himself as a victim rather than an aggressor because his role has been already cemented. Dominated by Ken’s social identity, this identity-prejudicial credibility deficit overwhelms all other narratives; leaving any understanding of the context of Ken's story - his vulnerability, his feelings of fear, and an alternative framing of his experience - absent.

This story is reminiscent of the one previously detailed on page 141 by Wesley, a Black service user at Site 1, who described a negative experience with the police and mental health professionals disbelieving his account due to his race and mental illness diagnosis. As per his report, he suffered racial discrimination and epistemic injustice because his arrest and subsequent detention were unwarranted, with professionals conferring undeservedly high credibility to his partner's account because of her status as a white middle-class female nurse, while assigning him no credibility.

Detention predisposes service users to ill-treatment and a sense of dehumanisation. Participants commonly described the sanctioned stigmatisation of their mental illness, with inhumane treatment from mental health professionals ascribing minimal value to their voices or opinions, as illustrated by Finn's account (a Black service user at Site 2):

> Interviewer: So, why do you think that when talking to the doctors directly they don't hear you or take your voice into account?
>
> Finn: Because most times is that when you're there on the ward, the doctors don't look at you as a normal human being. And that's not like an assumption or an opinion or whatever, that's actual fact. I believe that's actual deffo fact. No doctor or nurse that works in the mental health services actually look at us like normal people. They look at – there's a stigma behind the whole mental health service… once you're in there and you're taking medication, no matter what it is, even if it's not like to treat a mental health illness… No matter what, once you've gone into those types of facilities… they don't look at you or try to treat you like a normal human being anymore. They try to treat you like some animal basically - that's what it is like - they try to treat people like animals in there.

The interview data reveals that several AMHPs from Black backgrounds experienced some form of testimonial epistemic injustice, with white counterparts assigning lower credibility to their knowledge and competence owing to social identity-based prejudice.

While talking with Mary - a Black female AMHP - regarding her experience of working with service users from Black communities, she alluded to institutional racism within the mental health system, while describing that Black people in general - professionals and service users - suffered discrimination and were treated as less competent:

> Well, I'm also from the BME - Black minority ethnic group, so working as an AMHP and as a Black person, it's sometimes difficult with relation to both patients and colleagues. However, if somebody has worked with you for some time, their impression of you may change over time. But from the beginning, it is a bit challenging because working with another person who is not from the BME background may see you as not able to make the decision, which is challenging. But having experienced that for most aspect of my life, I've been able to adapt, and to overlook certain things and do what I've got to do, (Mary, a black female AMHP)
>
> Interviewer: Can you explain why people think that you cannot make a decision?
>
> Mary: Well, this follows the same institutional way of thinking - people from BME are not capable of doing many things, you know? It's been going on for a long time. Because you may not be speaking exactly their language or your accent is different - definitely going to be different from somebody brought up here, born here, and indigenous. And so, they think it's something different. So, you may not be able to do what they do. But this could also be because they do not know your background they don't understand that you are the same person who has gone to do the course and passed it, you know? And with flying colours and you have been practising. So, unless you have to work doubly hard in order to convince them that look, I can do this. And when they discover you can do it… but even then, some people still think like that… because of the bias - it's kind of unconscious bias.

This extract identifies the unconscious epistemic bias and institutional racism within the mental health system meaning Black people - including professionals - have to "work doubly hard" to be afforded equal epistemic status as their white counterparts.

Reflecting on this, the AMHPs described their experiences of doctors devaluing their credibility as knowers, "looking down on social workers" and devaluing their knowledge and legal interpretations:

> A female consultant and a doctor came to the team room and said to one of the AMHPs (Venus, a Black female with five years of experience) that Dr P has recommended for an admission of a patient he has just assessed at the unit, but they are struggling to find an independent doctor for second medical recommendation, so they wanted the AMHP to assess him under Section 4 to detain him for emergency reasons. Venus grimaced, appearing a bit surprised, and said Section 4 is for emergency. There seems to be lots of disagreement here as to whether the use of Section 4 is warranted/appropriate in the case of this patient.
>
> George (a Black male AMHP), steps in to say that if they think the risks is so high and they cannot get a Section 12 doctor in, they should take the patient to A&E as a place of safety until an independent doctor is found. The doctor did not share the AMHP's view, saying that the patient has already been assessed by them, "so, what's the point of taking them to A&E?" And that "it would not be appropriate to do so". In the end, Venus said that they would try and look for an independent doctor to come in to assess the patient under Section 3. The consultant and the doctor agreed and left the room.
>
> Venus turns around to me and said that sometimes some of these doctors tend to make you feel as though you don't know your stuff, and they know the law more than a trained AMHP. George said, "that is what they do, they tend to look down upon social workers. They think they know the law more than the AMHPs although the social workers have done training and learn about the MHA…" Venus said, "if you are not a confident and experience practitioner this sort of challenge by the doctor can make you question your competence, which could also affect your self-esteem". I thought there is an interesting power dynamic at play here between the doctors and AMHPs. The question is whose knowledge counts; who holds more power in this dynamic and the decision-making process? (Fieldnote 15, Week 13, Site 1)

Owing to their medical background and the dominance of the biomedical model within the mental health system, the doctors do not incorporate AMHP opinions regarding medication into their epistemic consideration. They assign lower credibility to the AMHPs because of their lack of medical training, as exemplified by George's account:

> I find it quite strange that somebody, you know… why not try other medication, Risperidone, and all other stuff, but they suggest Clozapine straight away. And when you try to explain to the doctor about these really because you know, because you are not medically trained, they don't listen to you really, they don't take on board what you are saying. So, these are the things that I find quite frustrating really. (George, a Black AMHP, Site 1)

In this power dynamic, AMHPs find themselves disadvantaged, potentially impacting their independent decision-making.

Even though elements of testimonial injustice were common in participants' accounts, few of the more experienced practitioners demonstrated testimonial justice in their practice or when discussing “blame culture”. In the previous chapter, I discussed a particularly striking example from my conversation with Mary, a Black female AMHP with twelve years of experience, who spoke of a case where the consultant was expected to discharge a service user as the Section 2 assessment period was close to expiration. The doctor asked her to make an application for Section 3 so that the person could be placed under CTO upon discharge. The AMHP felt it unfair to make further application for compulsory detention as the service user had made progress during the assessment period, but the doctor perceived the service user as likely to relapse in the community and present a risk to others, and consequently wanting him to be monitored in the community under CTO. Mary recounted that when she refused to make an application for Section 3 there was considerable pressure from her managers and other colleagues persuading her to reconsider her decision, but she “stuck to her gun”. The AMHP seemed to say that she did trust the patient's testimony whereas the doctor and the managers did not. She showed considerable resilience to withstand the pressure from her colleagues and the managers.

6.5 Epistemic exclusion

Epistemic exclusion occurs when someone is completely denied the possibility of becoming a contributing epistemic agent (Hookway, 2010). Epistemic exclusion overlaps with testimonial injustice where those social groups experiencing or subject to identity prejudice become vulnerable to unwarranted credibility deficit, and likewise, are disregarded when sharing information, including their views, opinions, and preferences. Unjustly denying or attributing lower credibility to someone because of prejudice based upon negative stereotypes associated with a person's social identity is a form of testimonial injustice, while denying someone their right to be a participating epistemic agent is a distinct form of epistemic exclusion. The data reveals that service users and their families were often excluded from decision-making about risk, and undermined in their capacity as knowers and participants during epistemic efforts to correctly determine whether to admit someone to a hospital for an assessment and/or treatment. Several AMHPs were often prepared to take detention decisions profoundly impacting the lives of vulnerable individuals without ascertaining or giving due regard to their views and preferences. This was observed during a discussion between Venus – a Black female AMHP with five years of experience at Site 1 - and a Section 12 doctor during an MHA assessment. This assessment sort to determine if a patient should be subject to Section 3 of the MHA to stay on the ward, potentially up to 6 months:

> The doctor asked the service user if she wanted to stay in hospital for a few more weeks for her treatment, but she answered, "no, I want to leave now". The service user then stood up and left the room. One of the nurses followed her, trying to persuade her to come back and continue with the assessment. The AMHP reacted by saying, "I think we have enough to make the decision".
>
> [This made me wonder whether the AMHP was suggesting that they already had the information they needed, so they could go ahead and make their decision without any further attempt to ascertain the views of the service user ?]
>
> The doctor's response to the AMHP's comment was, "it would be a shame if she was not given the opportunity to express her views about our recommendation". The doctor added that "it's better to try again and explain the

> purpose of the assessment and the reason for the decision” to the service user. (Fieldnote 5, Week 4, Site 1)

In this example, Venus - the AMHP - wanted the practitioners to make their decision using the information already gathered about the service user including the referral information, while rather ironically, the doctor advocated for more involvement from the service user and affording their inclusion. Following the assessment, my conversation with Venus revealed that she perceived the service user to be high-risk and deluded, and was considering the detention decision before the assessment even began. Venus said, “we go into every assessment with an open mind but with this particular case, I had already gathered all the information. She is currently under constant observation; the risks are high to herself, she’s still delusional, so having considered all that I would consider Section 3 before even talking to her”. Here, it seems to suggest the AMHP is indifferent to the service user ’s knowledge or views relating to the detention decision. The exchange between the AMHP and doctor also indicated a pre-determined outcome for the assessment, but they simply wanted to undertake a tick box exercise to evidence that they have obtained the service user ’s views over their decision.

Accounts from service users similarly revealed their exclusion by professionals from crucial decision-making over their care and treatment:

> Many times, they don't - when it comes to the decision-making of my care when I'm in there, they will write up their own report on what they think I should do and whatnot and what they think that is best to help me out. (Finn, a Black service user, Site 2)

Wesley echoed this impression of professional disregard (a Black service user, Site 1):

> They didn't involve me in anything. They said you need to be in hospital now.

Service users were excluded from the decision-making process by professionals who undervalued their experiences and narratives. Participants reported the concern of service users to be heard by the professionals who judged their lives, often based upon assumptions and prejudicial stereotypes, and lacking cultural awareness, as Venus - an experienced Black female AMHP of five years - explained:

> One of the biggest concerns is not being heard, whereby – yeah, that's been in the system for a long time. For them not being heard and the person who is assessing them and making a decision on their life is somebody who is probably – has no awareness of diversity - cultural diversity.

Participants described how professional power operates within the mental health system as a paternalistic culture developed by practitioners, often excluding service users from decisions relating to their lives under the guise of managing risk. Service users were often seen as the object of the epistemic practice of risk, rather than as participants within it (Scrutton, 2017). Professionals' risk intervention methods, such as using restraint to administer medication, were interpreted by service users as expressions of professional control, provoking feelings of anger, apathy, and mistrust. This is depicted in Ken's following account:

> Everything is by force, because of risk factors that they will always magnify… There was actually a time that an incident happened on the ward because I was refusing a medication… I had checked that it was a very old generation medication and give a lot of side effects, and when I was requesting to speak to the pharmacist so that I can get a breakdown of the medication and what exactly is doing because I'm interested in that stuff and I've research a lot, I've read a lot on it. Whether it's affecting my D1 receptor - D2 receptor - what is it doing to me? They didn't wanna give me that information and I had an issue with the medication that I was on at the time, it gave me arrhythmia in my heart. I had a very bad, uh, ECG result. So, they were gonna change my medication. But instead of letting me have influence like what you're talking about, having discussion… they took that away from me and said that by force they're going to inject me with the [medication] so, whether I like it or not – so, they were

> gonna call the team for me immediately to restrain me, and then I reacted and then that became an incident on the ward. But if I had a better relationship with them, it would have been a discussion rather than an incident. But it's that forceful nature that they have, and the fact that they see - they think you are aggressive so they always outnumber you and that can cause a - how can I put it? - can cause a fight or flight in you because you are cornered. (Ken, a Black service user at site 1)

Here, we can observe that practices devoid of working alliances - denying service users the role of contributing epistemic agents while imposing exclusive decisions on them - can create emotionally charged responses, reinforcing professionals' perceptions of a service user as an aggressor and an unreliable testifier.

6.6 Enhancing epistemic justice

6.6.1 Listening to service users and acting upon their interests

A common suggestion by participants over addressing epistemic injustice during the MHA assessment process was the necessity of not just listening to service users and their carers but also acting upon their views and recommendations. Participants in this study perceived that this was only achievable if professionals developed tolerance towards the opinions and wishes of individuals undergoing assessment. It would also help to prevent professional decision-making based upon preconceived beliefs that predisposed assessments to serious epistemic errors:

> [it is] very important to listen really well in [an] interview and what, you know, the person is actually saying rather than making blanket assumptions. Because if they say I will take my medication, you know, and I'm quite happy for somebody to come and see how it goes, you know? If I feel that they are capacitated to do that then I feel they should be given the chance. (Jane, a white female AMHP with nine years of experience, Site 2)

During our conversations, AMHPs talked about employing professional values such as the non-judgemental approach, while treating a person with dignity and equal value. These accounts propose listening to service users and interacting with them in less judgemental ways to promote epistemic justice, while simultaneously building trusting relationships and positive engagement, as explained by Vivian – a Black female AMHP with one year's experience at Site 1:

> They are able to feel free to talk to me because one of them told me, they said, "I don't know even know why I keep coming here Vivian, because I don't like coming here, this is a place for mad people". I said, "why do you think you've come here?" She says, "oh, because you don't judge me, you listen to me" and I do take her out to lunch sometimes. So, I don't judge, I make her feel like yeah, you're a human being. Yeah, you've had your struggles, you have all these challenges, but let's get you better. Let's get you back, you know? Take back control of your life, yeah?

The above extract shows that epistemic justice can be enhanced by professionals appreciating a service user's position, helping to empower them and strengthening their confidence to reclaim their lost voice by becoming full participants in matters relating to them. This entails cultivating practices recognising and taking into account the vulnerabilities of the speaker/service user, helping them to "take back control" of their life by increasing the agency of individuals in mental health distress. The service user referred to in this extract disliked certain aspects of the service, particularly the stigma attached to the environment where she was supposed to meet the practitioner, yet having a hearer/listener who was tolerant of her views and left her feeling listened to created a sense of being valued - resulting in her continuous engagement. This finding echoes Scrutton's (2017) assertion that adopting a listening position instead of "knowing best" will help reverse the stigma, sense of exclusion, and diminished control and choice that people with mental health problems, particularly from Black backgrounds, continue to experience.

6.6.2 Utility of advocacy for enhancing epistemic justice

Although less directly relevant to my research questions, the value of advocacy for promoting epistemic justice is a common theme intersecting with epistemic injustice and its inter-related concepts, supporting service user involvement in decision-making, enabling marginalised individuals to have a voice, and ensuring that the perspectives and preferences of service users are considered during the MHA assessment process. Participant accounts often referenced the importance of services like independent mental health advocacy (IMHA) and how their input facilitated and legitimised service users' knowledge and perspectives when made available during the MHA assessment process, both in the community and in hospitals. According to participants, the presence of an independent mental health advocate during the MHA assessment could help change communication that often privileges or favours third-person accounts or experts. During a conversation with Kevin – a Black male AMHP of ten years - regarding Black service users' experiences of the detention process and how to promote their involvement in the decision-making, he reflected on his experience of working with an independent mental health advocate and the role they played amplifying service users' voices throughout the detention process:

> Well, from my experience of IMHAs that I've worked with following people's detention, they've always been good at supporting professionals to kind of step back and hear what the patient has to say, looking at how what the patient is asking for can be achieved. Sometimes, professionals kind of gloss over things because they've already made up their own minds, but they've really been able to support professionals in actually thinking, "okay, well how could we make this work or could we make this work?" So, I think that that would be a helpful addition for a patient.

According to participants, the presence of an advocate during the MHA assessment can weaken the power inequalities found within the mental health system and during the MHA assessment process by exposing AMHP practice and decision-making to scrutiny:

> If [IMHA] was available… erm, it would – what I think it would do - it would give pause – it would have AMHPs and services give pause to think about their decision making more. Not that I'm saying we're doing the wrong thing or it's illegal… but if I know that this service user's husband or the mum is a solicitor, for example, more care – not care but more consideration is taken. You won't rush to that assessment [laughs] as much as you would do because of all the pressures. So, if you had an IMHA that pointed out things or requested - I think we don't get challenged enough as AMHPs. (Jason, a Black AMHP with five years of experience, Site 2)

This AMHP maintained that by exposing professional practice to scrutiny, they would be more inclined to consider other alternatives and less hasty in arriving at their detention decisions. This could facilitate more time listening to service users' accounts and preferences and considering wider social issues informing their decision-making.

Participants reported that the current arrangement whereby the IMHA service is only available to service users subject to detention or under CTOs is unfit for purpose, with it being more practicable and beneficial to service users for promoting epistemic justice if they were made available during MHA assessments in the community, as Jane – a white female AMHP with nine years of experience - explained:

> I think when [IMHAs] come to us it's almost too late. I think it needs to be earlier on and I think it needs to be available. You see, it's only really available for detained patients particularly Section 3, usually on a ward. It's just not there now. But actually, in the community - I mean, it would be fantastic because, you know, even in the community team where you are the care coordinator you're still kind of like - well you should do this and you should do that, because that's your job, you know? I mean you are engaging services as much as you can but there are limits and actually, if it was the case of an advocate being able to go out and kind of come to me and say, well actually this is what they're thinking about.

This extract suggests that community-based advocacy during the MHA assessment can promote service users' voices, and consequently, mitigate the constraints on epistemic agency identified by previous studies (Newbigging and Ridley, 2018).

There is evidence that the protocol-driven form of assessment in mental health service privileges certain ways of articulating testimonies (Carel and Kidd, 2014), including the use of "medical jargon" placing service users in a disadvantageous position during communicative exchanges. Participants claim this affects service user participation in decision-making, with AMHP accounts suggesting the presence of an independent mental health advocate during MHA assessments could help address this problem by clarifying things to the service user and strengthening their participation.

> An advocate really should be opened at any level, not only when they are CTOs or when they are detained… There is a set of protocols in terms of assessing that they go through, in answering your question that sometimes a lot of people after the assessment do not really understand because they are using a lot of medical jargon - medical terminology that the service user did not know. So, if they could get an advocate that could break it down to their own language - to their own level for them to understand - it will be better. (George, an AMHP with eleven years of experience, Site 1)

Frequent comments made by service users suggested a belief that the IMHA could represent their voices when acutely unwell and unable to express their views and/or articulate preferences:

> [Mental health professionals] have accountability because somebody is there to check that what they're doing is correct. It's just their presence alone will make them become more formal. And also, you have a witness so there's somebody to corroborate if anything goes wrong. And then also the mental health advocate will be like a linguist. It means that they'll be able to articulate what you can't articulate because, at the time that you are unwell, you're not the most articulate. So, the AMHP and the professionals sometimes will interpret things the way that they choose, but if you have somebody that's neutral do an interpretation with them, then it will be more efficient and more effective. (Ken, service user, Site 1)

The above extract implies that the presence of an advocate during the MHA assessment could expose AMHP practice to further scrutiny, and serve as a “witness” to interactions between mental health professionals and service users – preventing the human rights abuses and racialised risk assessments demonstrated in this research.

6.7 Conclusion

This chapter has explored various categories and instances of epistemic injustice that manifest during AMHP practice encounters and communication with service users from Black communities. It highlighted that MHA risk assessments are defined by unequal power dynamics privileging particular forms of knowledge, such as objectivity and third-person reports, over the personal experiences and anecdotal accounts of service users. The participants’ narratives demonstrated how professional power, the process and relational aspect of detention, organisational barriers, and restrictive interventions fortified within a legal framework limited epistemic agency. Furthermore, the dominance of risk in the MHA assessment and AMHPs’ deference to biomedical knowledge invalidated the social context, circumstances, and realities of people’s lives. The service user accounts confirmed how racial discrimination, identity-prejudicial credibility deficit, and status relegation occurring during testimonial injustice defined or embodied their experience of detention and pathways into the mental health system. More specifically, this chapter highlighted that service users and their families/carers were often considered “non-knowers”, excluded from decision-making relating to their lives, and denied positions as contributing epistemic agents. Consequently, they were often seen as objects of epistemic practices of risk rather than as participants within them. The data revealed that several Black professionals also experienced testimonial injustice from white colleagues assigning lesser credibility to their knowledge and competence due to prejudices derived from their social identity. Additionally, this chapter presented an important consideration discussed in participants' accounts for enhancing epistemic justice, including the facilitative role played by mental health advocates for enabling voices and exploring alternative framings of service user accounts and experiences during the MHA assessment process, especially in the community.

Chapter 7: Discussion

7.1 Introduction

This research study aimed to explore the key influences AMHPs consider when forming judgements about compulsory detention, examining how practitioners constructed risk when arriving at a decision. It also sought to explore the views and accounts of Black service users regarding the care they received and their experiences of detention, along with their perspectives about their level of involvement or participation in their care and treatment decisions. I utilised an ethnographic methodology encompassing observations, field notes, informal conversations, and follow-up field interviews with AMHPs and Black service users to enable a detailed data collection and analysis rooted in Fricker's theory of epistemic injustice and the applied sociological concept of risk work to provide a theoretical basis for exploring AMHPs' decision-making and Black service users' detention experience. In this chapter, I discuss my findings from previous research by revisiting the research questions, while appraising and evaluating the key themes regarding their contribution to the knowledge base, their general application to social work/mental health practice, and their implication for policy, practice, and service user experience. This chapter will also discuss the explanatory power of my theoretical framework comprised of risk work and epistemic injustice, assessing the limitations and strengths of the ethnographic methodology I utilised in this study, before detailing potential avenues for future research.

7.2 Summary of evidence from the thesis

The findings of this research confirmed a close relationship between the legal criteria for detention and the classification of risk; however, there was evidence of professionals operationalising relatively lower risk thresholds for Black service users, resulting in significantly more application of the MHA in their mental health care. The study demonstrated the mutually constitutive relationship between risk and ethnicity in detention-based decision-making, revealing racialised categorisations of risk, with AMHP decision-making continuing to be shaped by risk or public safety agendas. Professionals confessed anxiety and uncertainty about the possibility of Black service users posing risk to others and a desire to prevent this by enforcing restrictions on their liberty, both in the community and in the hospital. 'Dangerousness' has been absorbed into risk discourse, influencing professionals' risk thinking over mental health service users, particularly young Black men - who are predominantly classified as a risk to the public. My findings suggest that while the language of 'dangerousness' and many professional practice behaviours have shifted, underlying concerns remain over what drives the compulsory detention of Black people. This affects how professionals manage to perpetuate inequalities in practice, consigning young Black men to forces of oppression and punishment via a more sophisticated system which I term ‘risk veneer’. This conceptualises risk as a layer of ‘superficial refinement’, presenting a pretence of engaging in a highly-developed practice which remains brutalising and stigmatising, particularly for young Black men. This racist framework supports professionals to increase the stakes around risk, adopting restrictive interventions and measures related to race and ethnicity under the guise of assessment and management of risk. My research has demonstrated that racism in MHA assessments, prejudicial professional attitudes disadvantaging Black people, and the processes producing this disproportionality are challenging to see and identify without conducting detailed observational work. By examining face-to-face encounters between professionals and Black service users at the micro level, we can similarly discern the unequal power dynamics and professional attitudes towards certain social groups. A picture emerges of the contextual environment and the racial undercurrents impacting AMHP constructions of risk and decision-making concerning Black people with mental health needs.

My analysis of the observational data presented a nuanced and complex relationship between diagnostic practices and the lower risk thresholds operationalised by professionals for Black people. For example, schizophrenia meets a higher risk category requiring stronger anti-psychotic medication, impacting AMHP detention decisions relating to Black people; consequently, a high-risk label and schizophrenia diagnosis are also likelier to be linked with Black men in particular. This reinforces the argument that most mental health practitioners perceive serious mental health issues to be ascribed to particular social groups comprised of high-risk individuals, securing their preventative involuntary admission under the guise of so-called mental healthcare (Szmukler, 2001).

The AMHPs were often preoccupied with the risks of not detaining an assessed person but were invariably eased by understanding a family's capacity to contain or mitigate any risks associated with the person. Notably, the risks became lessened or intensified in very different ways according to a service user's race and ethnicity, particularly concerning a community's experience of police brutality. In cases where the nearest relatives or families from a Black community initiated a referral due to concerns they held about the risk to an individual, it raised the likelihood of AMHPs deciding to detain them. Black professionals shared an empathic recognition of the experience of racism, so despite not being mental health service users, understood the dynamics of race and racism.

The study showed the problematic ways that AMHPs experience and undertake risk work, suggesting that a bureaucratic emphasis on risk management strategies designed to improve safety paradoxically affected the trust and relationship-based practices considered integral for risk reduction. AMHPs were confronted with the challenge of championing social perspectives within the context of a dominant legal/biomedical model, multiagency working, organisational factors, resource implications, and 'blame culture'. AMHP autonomy is often assessed regarding their willingness to take risks despite medical professionals' reluctance. However, this study presents that AMHPs experienced diminished professional autonomy corresponding to the elevated uncertainty of risk work and the fear of blame following negative outcomes. The AMHPs' ability to exercise independent decision-making incorporating social perspectives facilitating less restrictive options than detention was strongly connected to resource availability. The participants highlighted diminished resources as a systemic issue leaving service users unable to access the support necessary for mitigating crises and preventing detention. Consequently, this absence of power over resource allocation and alternatives to detention impacted the AMHP role, their interpretation of risk, and decision-making independence.

Both professionals and Black service users perceived epistemic injustice as a structural component of Black service users' detention experiences, with a combination of professional power, the process and relational aspects of detention, organisational barriers, and restrictive interventions underpinned by legislative framework limited the epistemic agency of service users. The dominance of risk in the MHA assessment and AMHPs' deference to biomedical knowledge invalidated the social contexts, circumstances, and realities of people's lives. Black service users' accounts demonstrated how racial discrimination, “identity-prejudicial credibility deficit” (Fricker, 2007, p. 28), and the status demotion generated from testimonial injustice defined and embodied detention experiences and pathways into the mental health system. Specifically, there was evidence that service users and their families/carers were often deemed ‘non-knowers’, excluded from decision-making relating to their lives denying their potential to become contributing epistemic agents, and defining service users as objects of epistemic practices of risk instead of participants within them.

This study has contributed a further understanding of how epistemic/testimonial injustice manifests within the mental health service, revealing how Black service users are more vulnerable to its impact than white counterparts owing to the duality of stigma (Wilkinson, 1998) and the negative stereotypes experienced when Black and possessing a mental disorder diagnosis. Interestingly, the accounts of Black AMHP professionals suggest their systematic undervaluing as knowers, while being considered less competent because of negative stereotypes associated with their racial and social identity.

Notably, there were valuable considerations in participants' accounts about ways to enhance epistemic justice, including the facilitative role of independent mental health advocates for enabling speech and exploring alternative framings of Black service users' accounts and experiences during the MHA assessment process, especially in the community. This study reinforces the argument that professionals adopting listening positions giving due regard to service user preferences and choices instead of 'knowing best' would vastly help to reverse the stigma, exclusion, and diminished control and choices experienced by people with mental health problems, particularly those from Black backgrounds.

7.3 Risk as a key determinant in AMHP detention decisions

While exploring the key influences formulating AMHP judgements about detention, it became clear that their decision-making heavily relied on their understanding and construction of risk; an unsurprising finding considering the many examples in the literature discussing the dominance of risk in mental health policy and practice (Warner *et al.*, 2017; Thomas-Glover, 2011). My analysis of the data demonstrates that AMHPs construct cases by identifying the nature of risk surrounding an individual undergoing assessment, incorporating other clinical risk indicators including a person's vulnerability, professional understanding of their mental illness, medication compliance, and history of 'risky' behaviours. This reaffirms findings from earlier literature suggesting that medical and risk discourses were deployed by professionals to justify admission and detention (Buckland, 2016; O'Hare *et al.*, 2013); however, while focusing on risk as a key determinant of AMHPs' decision-making may initially appear universally applicable to all mental health service users, further analysis of my data shows that practitioners' classifications and conceptualisations of risk were strongly influenced by a service user's race and ethnicity. This will be thoroughly explored in the following discussion of racialised categorisations of risk.

While the evidence suggests that AMHPs conceptualised risk factors according to the symptoms of a person's mental illness (Fistein *et al.*, 2016; Simpson, 2020), the family dimension was another element influencing their decisions - the significance of which will be discussed later. Service users' parents or carers were often perceived as protective factors, with consideration placed on their role in making a referral for an MHA assessment and providing evidence for an AMHP to construct risk as high and warranting hospital admission.

Focus often fell on an assessed person's lack of control or self-restraint rendering them 'vulnerable' or at risk of harm from others, with AMHP appearing to construct their cases by deploying their risk knowledge alongside notions of vulnerability, with the service user positioned as a passive agencyless recipient requiring professional intervention (Keating and Williams, 2000). This reinforced and strengthened the power of professionals in their decision-making, using an individual's vulnerability as an implicit "moral justification for stronger social control mechanisms" (Brown, 2012, p. 46), such as detention.

The AMHPs' interpretations and constructions of risk were strongly associated with a person exhibiting a mental disorder necessitating hospitalisation. There was evidence of an inherent identification of causative relationships, with a person's presentation or 'risky' behaviour functioning as a manifestation of their mental illness (Brammer, 2020). My analysis indicates that the AMHP decision-making process is framed by the concept of risk (Gale *et al.*, 2016), identifying, assessing, and handling behaviours by mentally disordered persons deemed risky. While I cannot rule out the possibility at the referral stage of other professionals involved in MHA assessments employing standardised risk protocols to assess risk, there was no evidence that the AMHPs in this research utilised any objective or prescriptive risk assessment tool to develop decisions.

In addition to linking risk with a mental disorder diagnosis, AMHPs constructed risk from the features they observed in a person's behaviour, such as non-compliance with medication. This concurred with evidence in the literature identifying cooperation over medication as being integral to AMHP decision-making (Stone, 2017). Moreover, my findings indicate that in circumstances where an assessed person was initially unaware that they had a mental illness necessitating medication, AMHPs described them as lacking understanding or knowledge about the potential risks relating to their mental disorder. Consequently, practitioners would rate risk highly, emphasising the likelihood of that person refusing medication in the community.

My analysis revealed further evidence that even when a person undergoing MHA assessment complied with medication but rejected professional perspectives regarding specific behaviours as symptomatic of mental illness, AMHPs would still construct risk as 'high'. This partly substantiates the significance of a detention decision of the assessed person's acceptance of their mental health status and illness and the AMHP's trust in them taking their prescribed medication (Abbott 2018). The current study corroborates that in situations where the service user refused medication because of doubts surrounding the nature of their mental illness, an AMHP would still proceed to deprive them of their liberty, detaining them under Section 2 to allow doctors to assess the person. Therefore, when there is uncertainty surrounding the nature of the person's mental illness, risk language would be mobilised and applied to the person's situation to legitimise (Stanley, 2018) an AMHP's detention decision.

This study demonstrates that when making detention decisions, AMHPs consider the nature of the risk being dealt with while applying their risk knowledge to decide whether a social perspective or recovery model could be considered. Participants confessed the difficulty of managing risk to others when accounting for social perspectives. When a person was deemed a risk to themselves, AMHPs were more likely to engage in positive risk-taking than when a person was considered 'risky' or a risk to others, utilising the social model to consider the least restrictive options. This endorsed the centrality of public protection in AMHP decision-making and conceptualisations of risk identified by previous studies (Coffey, 2012), and the argument that the concept of risk in mental health policy and practice has continuously been coupled with the risks people with mental health difficulties pose to the public, in contrast with the risks they face (Warner *et al.*, 2017). The majority of AMHPs in this research constructed risk through gut feeling and anxiety over uncertainty relating to a person's mental health condition, preoccupied with the impact on the public of the risk associated with an individual if they were not detained in a psychiatric hospital. The role of risk in detention decisions should be explored and understood in the context of evidence from previous studies that Black people - particularly young Black men - are likelier than their white counterparts to be classified or assessed as high-risk individuals requiring detention (Fernando, 2010; Bhui *et al.*, 2018). This means that they are disproportionately affected by decisions heavily reliant on professional constructions of 'risk to the public'.

7.3.1 Feasibility of managing risks in the community

A stable feature of both the interviews and observational data was that AMHPs considered both the safety and viability of a person undergoing assessment to be managed in the community, consistent with the findings of earlier studies (Abbott, 2018). AMHPs acknowledged their role required exploring all viable alternatives to compulsory admission, and whether there were community services - including home treatment teams - that could support a person in the community while considering the risks presented by the assessed person. My findings suggest the AMHPs avoided any positive risk of allowing a person to remain in the community for support and treatment in cases where a referral noted that a person had a history of being referred or admitted to a Psychiatric Intensive Care Unit (PICU), considering this synonymous with ‘high risk’. There was evidence that some AMHPs made *a priori* decisions over risk levels, justifying their decisions to opt for more restrictive options by using referral information and prior history of detention without due consideration of community services and other alternatives.

The AMHPs appeared to focus on the notion of “absolute safety” (Warner, 2007, p. 30) reflected in numerous historical policy documents such as the DoH’s 1998 white paper on mental health policy titled Modernising Mental Health Services which emphasised safety. My findings describe heightened anxiety among AMHPs over their responsibility to “manage the risk” or keep people safe in the community following a referral or medical recommendation for MHA assessment. The AMHPs appeared to deploy their risk knowledge not only when classifying the potential risk presented by a service user remaining in the community, but also when attempting to control future uncertainty. For the AMHPs in this study, managing risk in the community was linked to regulating their anxiety (Brown and Gale, 2013), with decisions relating to risk legitimising detention even before an event occurred (Stanley, 2018). This implied worry and anxiety over what might occur, requiring immediate intervention because of future uncertainties, with AMHPs often preoccupied with the risks of not detaining an assessed person due to the complexities and uncertainties surrounding such decisions.

The AMHPs admitted to minimising risk by devising individual methods, often outside of that prescribed by law, sometimes including coercive means for preventing risk escalation where there was uncertainty. From a ‘risk work’ perspective, AMHPs attempted to circumvent the limits of their risk knowledge in deciding other means of managing uncertainty (Veltkamp and Brown, 2017), such as engaging in risk-averse or defensive practices (Warner, 2015).

My analysis of the observational data describes how disagreements between AMHPs and doctors over whether a person should be detained or remain in the community saw AMHPs using veiled threats and coercive language towards service users to force their behaviour to appease the doctors so they could remain in the community. The AMHPs saw this as a tool for risk intervention, but it ultimately affected client relationships by breeding suspicion, mistrust, and nonengagement leading to the practitioner’s diminished ability to understand the risks concerning an individual (Heyman *et al.*, 2012; Brown and Gale, 2018).

7.3.2 Family’s capacity to contain or mitigate risks

In connection with managing risk within the community, this study is absent examples of a family’s capacity to contain or mitigate risks being damaged by potential tensions within the family, as seen in earlier literature (Solanki, 2020). Instead, one of the things that AMHPs considered when making decisions about whether to detain a person under assessment was the possibility of carers or family members being able to manage risk in the community. The AMHPs acknowledged that there were no easy answers when forming judgements over risks containing multiple uncertainties - particularly in cases related to suicidal ideations - however, a strong social support network including family members within the household together with community resources facilitated their decisions. Although participants felt unable to eradicate risk due to its unpredictable and dynamic nature, there was a consensus that the presence of adequate family support eased the pressure on the AMHP to make decisions.

Participants generally decided to detain a person following family members or parents raising concerns about them being within the home, with their vulnerability in the context of the risk a service user presented to themselves and their household. Similarly, my analysis demonstrates that in cases where the nearest relatives or families from a Black community initiated a referral due to concerns they held about risks to the individual, it raised the likelihood of AMHPs deciding to detain the person. During my discussion with one of the Black female AMHPs regarding the reasons leading to her decision to detain a Black service user she assessed, she detailed the complexities of risk relating to the police’s role in mental health and the structural inequalities identified in earlier literature concerning Black communities and policing

(Fernando, 2017; Singh *et al.*, 2013). She conceptualised a certain level of risk from a Black woman's decision to call the police on her son, explaining that the mother knew she was potentially exposing her son to all the awful things that police have done to young Black men, telling her - the professional - how high the risk must be for the family. She suggested that while the decision for any family to refer their child would be potentially very difficult, for some families there are different equations and actually what this Black family were doing was calculating the risk associated with calling the police against not doing so. The AMHP felt young Black men's experiences of police involvement were fraught with fear and adverse outcomes, and that parents from Black communities were unlikely to initiate police involvement unless the risks had become "unmanageable". The Black professional appeared to use her personal experience regarding her ethnic background - among other factors - to conceptualise the risks and arrive at her detention decision. There was a strong sense of empathy in her account; suggesting that she could assess the risk level for that family because the mother of a young Black male was prepared to take the significant step of reporting her son to the police, which someone from a Black community would be acutely aware would elevate the risks he faced through their involvement. The AMHP identified this as an indicator of high risk, different to what her reading would be if this had come from a white family. Black professionals were empathetic to the experience of racism, so even though they are not mental health service users they comprehended the dynamics of race and racism.

7.4 Racialised categorisations of risk

I now fully detail the specific role that race and ethnicity play in shaping MHA risk assessments and AMHPs' detention decisions. This research has presented how many professionals - including AMHPs - conceptualise risk as intimately entwined with ethnicity and racism, and *vice versa*. When people think of race as another way of conceptualising risk, they become mutually integral. Race constitutes risk and risk constitutes race, each shaping the other. If you present a Black man you may as well present a high risk; if you present a high risk you might as well identify a Black man.

While previous research studies have afforded racism a part of Black people's detention experience (Solanki, 2020; Fernando, 2010), my research has extended this to reveal how racism is deeply embedded in both MHA risk assessments and AMHP decision-making. The findings of this research show that mental health professionals continue to classify and define risk according to someone's colour and ethnic background, with young Black men undergoing unequal risk assessments compared to white people and receiving the inferior mental healthcare provision highlighted by the supporting documents of the independent review of the MHA 1983 (DHSC, 2019c).

Participants in this research described how racism was inherent to MHA assessments, especially from medical professionals constructing risk unfavourably concerning Black people when compared to the white majority population. Some of the AMHPs seemed to suggest a desire to be fair and adhere to the guiding principles of the MHA 1983 concerning treating people with respect and dignity regardless of their race (DoH, 2015); however, my ethnographic study found no evidence of how they intended to challenge discriminatory practices by other professionals who continued to violate MHA principles by making race-based decisions. Social workers are obligated to promote social justice for the service users they work with, including a responsibility to challenge any form of racial discrimination or act of oppression based on race and ethnicity (BASW, 2021), so one would hope this might translate into practice. Consequently, professional fears of discussing racism safely and candidly or challenging the ‘stereotypical views’ about Black people previously detailed in the literature (Keating and Robertson, 2004, p. 445) will remain unchanged.

Racism and discrimination manifest differently during the mental health assessment process. My findings show that in rare situations where a professional was reported to have used explicitly racist language or incidents of racism were identified in referral documents, some of the more experienced AMHPs - particularly those from Black backgrounds - were able to challenge it. However, it is worth emphasising that these incidents were intermittent because participants’ accounts suggested that racism has become implicit within the context of the MHA assessment process.

There was evidence that professionals, especially clinicians, linked Black people’s behaviour with criminality instead of as a function of their mental illness. In contrast, similar behaviour from a white person was more likely to be attributed to mental ill-health and not necessarily criminalised. Combined with professionals’ perceptions of young Black men as violent and high-risk, this may partly explain why people from this particular social group holding a mental illness diagnosis are subjected to or experience a higher rate of contact with the criminal justice system, as highlighted in previous studies (Bhui *et al.*, 2003; Singh *et al.*, 2007). My analysis also demonstrates that risks were mitigated or intensified in fluctuating ways according to a service user’s race and ethnicity, particularly in a community's experience of police brutality.

The majority of AMHPs described Black people's experiences of MHA assessments as “unfair”, reflecting the injustices, restrictions, and coercive interventions they are subjected to within the mental health services, not only in the hospital but also within the community. This was exemplified by the account of Mary, an AMHP with twelve years of experience when a doctor had asked her to apply for a Section 3 so that a young Black man could be placed under CTO upon discharge. My analysis suggests that there was no evidence that the Black service user met the criteria for further restrictive intervention upon discharge, with the professional's anxiety over the possibility of his risk to others based upon perceptions associated with the service user's race and ethnicity. While the mental health professional did not express this explicitly, their attempt to “circumvent the law” to ensure this person's containment or monitoring through CTO within the community epitomised the disproportionate use of these powers over Black people, described in earlier literature as coercive, discriminatory, and race surveillance (Mind, 2018).

Conceivably, the reason why most of the AMHPs in this study were unable to challenge these injustices against Black people, in particular, is because they faced not merely doctors but the entirety of clinical managerial practice. My research findings support the evidence that despite policy initiatives such as the 2005 Delivering Race Equality programme and the implementation of the Equality Act 2010, the long-standing issues regarding the overrepresentation of Black people in the more restrictive aspects of mental health care and ethnic inequality in service experience (Bhui *et al.*, 2018) remain unaffected.

The MHA 1983 code of practice encourages AMHPs and other professionals involved in detention decisions to consider the least restrictive options or alternative mental healthcare provisions to maximise independence. Despite decades of investment to realise this (Bhui *et al.*, 2018), there remains evidence of racial disparity and lower risk thresholds when applying the MHA. Participants gave vivid descriptions of lower risk thresholds being operationalised by professionals over Black service users, resulting in significantly greater use of the MHA for this particular social group. When discussing how they constructed cases and assessed risk during the MHA assessment, the AMHPs disclosed that the onset for Black people's assessment under the MHA was very low due to professionals' lack of cultural understanding and negative perceptions of Black people's behaviour. The lower risk threshold for MHA assessments of Black people may in part account for the reason why people from these communities are likelier to be assessed for compulsory admission to psychiatric hospitals, as discussed in previous studies (DHSC, 2019c; Webber and Huxley, 2004).

Due to lower risk thresholds for detention and professional fears of making mistakes, it could be problematic for AMHPs to "speak back" to the risk narrative, because refusing to construct a case or classify a Black service user as risky and requiring compulsory admission could be deemed poor practice in the event of negative events occurring. The perceived 'riskiness' of Black service users translates into an increased risk for professionals who may suffer severe consequences for bad outcomes perpetrated by Black service users compared with similar from white counterparts, due to racialised public safety and risk agendas. If Black service users are represented as high-risk individuals requiring restrictive intervention even within the community - as reflected in the disproportionate use of CTOs over them (DHSC, 2018; NHS Digital, 2021) – AMHP decisions concerning this particular social group will become defensive for fear of making a mistake damaging the reputation of an organisation (Brown and Calnan, 2013).

Challenging risk knowledge during MHA assessments can be problematic and subject to the ambiguities around risk, and this area has been largely unexplored by academia. My findings suggest that AMHPs' decision-making and risk interventions were often under-exposed to interrogation, largely due to the low-risk threshold criteria, particularly for Black service users. There was a consensus among the participants of a comparatively lower threshold being operationalised for Black service users, and coupled with the irrelevance to their mental disorders of many of the referrals and medical recommendations for the compulsory admission of Black people, these appeared rather due to their race and professional prejudices towards them. This reinforces earlier evidence of Black people's experiences of racism within the mental health system (Solanki, 2020; Fernando, 2010).

The lower risk thresholds utilised in Black service users' MHA assessments are closely connected with professional perceptions of the dangerousness of young Black men in particular, with both consequently impacting detention decision-making. Theorising the relationship between concepts of dangerousness and risk, Douglas (1998, p. 24) describes risk as "danger" and high risk as "lots of danger". 'Dangerousness' has now been absorbed into risk discourse, particularly professional risk thinking concerning mental health and Black service users in particular. This research corroborates evidence that professional approaches to the MHA assessments of Black people continue to rely on negative racial stereotypes of dangerousness (DHSC, 2019c).

My findings revealed that many professionals perceived Black people to be dangerous and posing a risk to others, with this becoming integral to the translation of risk knowledge in their daily practice. There was evidence that Black service users presenting challenging behaviours were often described in their medical records in much stronger terms than their white counterparts, likely due to the perceived riskiness and danger associated with this group. Although the Mental Health Act (MHA) requires professionals to assess 'risk to self or others' (DoH, 2015), the assessment of Black service users is often shaped by racialised perceptions, wherein they are disproportionately viewed as posing a risk to others rather than being at risk themselves. This phenomenon represents a form of epistemic injustice (Fricker, 2007) as the preferences, lived experiences, and social contexts of Black service users are devalued or dismissed once they are categorised as a threat to public safety. Risk constructed through interpretations of inherent dangerousness will ultimately impact how professionals engage with Black people, often resulting in coercive interventions to prevent escalating the ‘perceived’ risk. Some participants in this study admitted to devising their methods to minimise risk outside of that prescribed by the law.

The embedded racial bias (Hall *et al.*, 2015) and construction of young Black men in particular as high-risk and dangerous in the community was a source of anxiety among professionals, often resulting in defensive practices (Warner, 2006; 2015). Many professionals were wary of the potential for young Black service users to do something terrible and ultimately leave them to be held accountable, balanced alongside the risk of being seen as discriminatory or unjust towards Black people.

This research suggests that while language around dangerousness and many professional practice behaviours have shifted, the underlying issues driving the compulsory detention of Black people remain. This has evolved into a more sophisticated system for forcing young Black men towards oppression and punishment. This study details the powerful processes mobilising racism under the banner of risk.

7.4.1 Racialised diagnostic practices

Participants in this study reported that racial biases were ingrained within diagnostic practices, with Black people being more likely to be diagnosed with schizophrenia than their white counterparts. This supports earlier literature detailing how racist attitudes are entrenched in the mental health diagnostic process (Fernando, 2017), with my analysis suggesting a nuanced and complex relationship between diagnosis and the lower risk thresholds operationalised for Black people. Schizophrenia falls within the higher risk category necessitating stronger anti-psychotic medication, impacting AMHP detention decisions relating to Black people, particularly young Black men. This reinforces the argument that mental health practitioners generally perceive serious mental health issues to be ascribed to certain social groups categorised as containing high-risk individuals, securing their preventative involuntary admission under the guise of so-called mental healthcare (Szmukler, 2001). Predictably, this high-risk label is more likely to be assigned to Black men with a schizophrenia diagnosis (Marie & Miles, 2008).

This research suggests that people with comparative mental illness symptoms are likely to experience divergent outcomes dependent on their race or ethnicity regarding diagnosis, prognosis, treatment pathways, and the application of an MHA assessment. Moreover, professionals often possessed limited knowledge of Black peoples' cultural and religious beliefs, incorrectly defining them as products of their mental disorders. Participants highlighted that ignorance of Black lives coupled with unconscious biases and prejudices based on stereotypes partly accounts for the overrepresentation of psychotic diagnoses among Black people (Nazroo *et al.*, 2019; Fernando, 2017).

My findings reveal that professional perceptions of Black people as loud and presenting differently influences the number of schizophrenia diagnoses attributed to this particular social group. Participants frequently believed that white people displaying symptoms of psychosis were often diagnosed with schizoaffective disorder while a Black person exhibiting similar "becomes schizophrenia". This concurs with Merino *et al.*'s (2018) study highlighting the underdiagnoses of affective disorders and overdiagnosis of psychotic disorders in racialised minorities. My research provides further evidence of professionals' poor understanding of Black people's behaviour, with racial biases and high-risk associations partly accounting for this. Moreover, this indicates that it is not the overt race-based prejudice of mental health professionals generating the disproportionate diagnosis of mental disorders and the detention of Black people, but the implicit biases and racist attitudes firmly established in the diagnostic process only discernible following my analysis of my observational data.

Many AMHPs are aware of the 'over-representation' of certain groups and the diagnosis practices perpetuating racism; however, they often fail to demonstrate how they seek to control and challenge the biases or prejudices highlighted. This could be due to a blame culture and the medical model's dominance within the mental health system (Hall, 2017). This partially reinforces the evidence that social workers/AMHPs appear "complicit and silent" over issues relating to race (Keating, 2016, p. 180). AMHPs struggle to exercise their autonomy in decisions regarding diagnosis, treatment, and medication, sometimes facing testimonial injustice from medical professionals discrediting their knowledge.

It is challenging to see and identify the racism in MHA assessments or the professional prejudice disadvantaging Black people without conducting detailed observational work. Examining in-person encounters between professionals and Black service users reveals the unequal power dynamics and professionals' attitudes towards these social groups. A picture emerges of the contextual environment and the racial undercurrents impacting AMHP constructions of risk and their decision-making concerning Black people with mental health problems.

If mental health professionals - legally obligated to conduct MHA assessments while promoting social justice and human rights - still hold prejudicial attitudes towards specific social groups such as young Black men, how can their detention decisions be based on accurate and fair risk assessments? If we do not confront the discriminatory and prejudicial attitudes evidenced in this ethnographic study, or provide alternative framings for Black service users' experiences, knowledge, and preferences when receiving MHA assessments, the longstanding and intractable ethnic inequalities in mental healthcare will persist.

7.5 The irony of risk management practices in MHA assessment

This study presents how AMHPs experience risk work, demonstrating how the bureaucratic emphasis on risk management strategies designed for improving safety paradoxically affects trust and relationship-based practice among AMHPs, which are important for reducing risk. The AMHP decision-making process is influenced by risk and its management, emphasising how the concept of risk is utilised to describe and manage it within everyday professional practice. Evidence suggests that risk continues to be the "major organising paradigm" (Warner *et al*. 2017, p.1) in MHA assessments. Participants described making detention decisions over Black people and what influenced their judgements, noting the difficulties of interpreting and handling risk, alongside its impact on the practice and rights-driven and user-focused social perspective aspects of the AMHP role. Managerial culture and protocol-driven practice prioritising deadlines affected AMHP's performance and the requirement to involve service users in decision-making.

While AMHPs recognised the necessity of risk management practices for enhancing service user safety, they stated the growing paperwork and bureaucratic processes associated with MHA assessments impacted everyday practice and decision-making. Tensions arose when converting risk knowledge into practice, damaging the established trust (Brown and Calnan, 2013), relationship-based work, and user involvement required for effective risk management. While recording and documenting decisions is ultimately beneficial for all involved, the extensive paperwork associated with identifying and managing risk was often challenging for practitioners because of its demands on their time and ability to exploit embodied knowledge and skills for making informed decisions for Black service users while promoting their rights and self-determination.

Organisational factors - such as data monitoring and practitioner liability for risk management failures - significantly influenced decision-making, with case audits and other risk management practices used to hold AMHPs accountable. Accounts of professionals losing their jobs and livelihoods for not adhering to risk management measures added pressure on AMHPs and their decision-making. These organisational factors fuelled defensive practices due to fear of being held responsible for any future bad outcomes (Warner, 2006). Consequently, AMHPs’ decision making is influenced less by individual discretion and more by systemic pressures, risk-averse organisational cultures, and structural constraints. While some AMHPs openly admitted practising defensively and adopting risk-averse approaches, certain senior practitioners thoughtfully and critically considered the balance between compliance with risk management protocols and advocating for the best interests of service users.

AMHPs unanimously identified that the time spent with service users building trust and establishing relationships was vital for understanding an individual and their social circumstances for minimising risk and enhancing positive risk-taking. However, this was affected by the bureaucratic emphasis on risk management. The efficacy of risk management mechanisms - including pharmacological interventions - depends on service user cooperation; however, the orientation of mental health services towards control and risk interventions such as involuntary admission hinders cooperation, whereby restricting someone's freedom incentivises a person to recapture it where they can, resulting in disengagement or obstruction (Maidment *et al.*, 2011). This tilt towards control over care, and the strategies employed to reduce calculated risks can ironically exacerbate service user vulnerability and place them at risk. This corroborates earlier evidence that the restrictive and coercive approaches associated with risk management are likely to dissuade service users, particularly from Black communities, from contacting services and accessing support before reaching a crisis point (Mind, 2004). Although this view is not exclusively confined to Black service users, they are most often affected because of their 'high-risk' characterisation, experiencing the most oppressive aspects of mental healthcare (Bhui *et al.*, 2018).

Black service user narratives of encountering AMHPs appear to support this, distrusting their assessment team due to their earlier risk intervention experiences and the lack of an established relationship with the professionals. They believed practitioners made *a priori* decisions over detention, with their choices or preferences marginalised and their testimony ignored, thus creating their noncompliance. However, these conflicts were less evident for Black AMHPs, several of whom reported that Black service users identified and better cooperated due to their shared social identity.

In summary, the differing perspectives and experiences of AMHPs and Black service users demonstrate the tensions of in-person risk work, with risk management and protocol-driven procedures designed for minimising risk paradoxically creating mistrust services among users, undermining their cooperation and placing them at risk of practitioners’ defensive approaches and interventions.

7.6 What happened to AMHP autonomy and the obligation to apply social perspective?

Most practitioners doubt their ability to exercise independent decision-making within the context of multiagency working, organisational factors, resource implications, and ‘blame culture’. Fearing blame for bad outcomes or potential risks of harm, AMHPs felt vulnerable when contradicting two medical recommendations, and lacked the confidence to trust their judgement. This contradicts Peay’s (2003) earlier study determining that following a disagreement or conflict between an AMHP and a clinician over detention decision-making, the AMHP will normally triumph.

Some AMHPs perceive themselves as elements of the mental health system, with detention decision-making a collective endeavour rather than the responsibility of a single professional exercising complete discretionary power. This hints at the complex diversity of detention decisions and the dynamics between AMHPs and doctors.

Theoretically, AMHPs maintain a legal mandate to independently make decisions that incorporate social perspectives into their judgements (DoH, 2015) by working to promote positive risk-taking, relationship-based practice, user participation, and rights-based interventions to resolve the social determinants of mental health problems, particularly for Black people who experience poorer healthcare outcomes. However, this ethnographic study demonstrates an in-practice culture that paints a different picture. From a legal consciousness perspective, there is a gap between AMHPs' textbook understanding of the legislation and its application (Silbey, 2005), with how practitioners understand, experience, and act concerning the law dependent on practice realities. My research presents AMHPs finding risk work tricky in situations requiring assertiveness, prevented from making the independent decisions required by the legal code of practice within a context dominated by the medical model.

The medical model centres symptoms and compliance with medication, reinforcing the risk-averse strategies more likely to lead to admission, and leaving positive risk-taking and social model approaches more likely to lead to least restrictive options as the domain of the AMHPs. However, the majority of AMHPs alluded to retreating from potential uncertainty and liability for negative outcomes by engaging in defensive and risk-averse practices, consequently fuelling the dominance of the biomedical model in detention decisions, and corroborating earlier literature that fear of accountability coerces AMHP detention decisions (Coffey *et al.*, 2017; Fistein *et al.*, 2016).

Given their MHA-enshrined level of discretion and independence over detention decisions, AMHPs were often wary of adverse consequences, with a risk of being held personally accountable (Golightley 2014) when making a decision contrary to medical opinion. An AMHP’s ability to construct autonomous decisions utilising the social model in practice can be dependent on experience and skill set, however, my findings show that many AMHPs, including the experienced, adopt precautionary approaches by making decisions in harmony with the medical perspective. This partly supports earlier evidence of social workers resorting to orthodox bio-medical narratives and the accompanying risk language (Campbell, 2010) for detention decisions rather than relying on their knowledge. This may be the easiest option for professional decision-makers but will not be in a service user's interest.

The AMHPs in this research meet great difficulty when affirming an independent decision, especially when other professionals hold pre-determined positions over what needs to happen. This is illustrated in the poignant account of an experienced practitioner detailing the immense pressure she faces from other professionals within an assessment team who not only attempt to prevent her independent decision-making but also seek to convince her that she is wrong. This hinders positive risk-taking and engenders more precautionary approaches and defensive practices by professionals (Warner, 2015).

All the AMHPs in this research were aware of their training to discharge a specific legal function, with their decisions profoundly impacting service users, particularly those from Black communities who are disproportionately affected by MHA assessments (DHSC, 2019c). AMHPs clearly distinguish between lay understandings and their professional risk knowledge acquired through training affording them a degree of power and status; their professional judgement operates in tandem with their specialised education legitimising their decisions. I concur that AMHPs' specific training and legal mandate over detention decisions should enable their independent operation. However, this study reveals a working environment that suppresses autonomous decision-making by AMHPs and undermines their discretionary power.

Additionally, AMHPs should be ‘independent arbiters’ championing service user rights, maintaining an independent viewpoint, and applying a holistic social perspective to counterbalance and challenge the narrow medical model (Hemmington, 2023). AMHP autonomy is often assessed through their readiness to take risks in the face of medical professionals’ reluctance. However, this study presents AMHPs experiencing diminished professional autonomy due to the uncertainty of risk work, with several AMHPs uncritically accepting risk assessments from medical professionals due to fear of accountability. While earlier research presented AMHPs as possessing the knowledge and autonomy for promoting social perspectives when prompted through case vignettes (Peay 2003), this ethnographic study identified how in real-life situations, AMHPs often chose the least complicated option of acting in congruence with medical opinion to detain a person, and conflicting with their professional imperative to exercise discretion and consider social perspectives (Hemmington, 2023). I argue that the AMHPs' incapability to fulfil these legally-defined obligations significantly impacts Black service users who the literature identifies face multiple social issues and disadvantages such as isolation, unemployment, marginalisation, low income, and social exclusion (Campbell, 2010).

Several AMHPs alluded to collective responsibility should something go wrong, with their construction of risk factors dependent upon the perception of other professionals within the multi-agency team. In avoiding solitary judgment, opportunities for positive risk-taking decline for service users. Given the prevalence of risk and the medical model driving defensive practice, doctors and clinicians continue to wield substantial power within the multi-disciplinary setting. While most AMHPs acknowledged the rarity of them exercising an independent decision within such a working environment, others with more practice experience mentioned their ability to challenge medical recommendations and make independent decisions depending on their practice wisdom, confidence, and assertiveness. This was demonstrated by a senior AMHP practitioner with ten years of experience suggesting that experienced workers became more assertive when negotiating with the doctors, and better able to exercise their discretionary authority over detention decisions.

This study shows how an AMHP's ability to compose independent decisions and apply social perspectives facilitating less restrictive options than detention is often dependent on resource availability. Participants highlighted this as a systemic issue leaving service users unable to access support for mitigating crises and preventing detention. The absence of power over resources and alternatives to detention impacts the AMHPs' role, their interpretation of risk, and independence, consistent with earlier evidence that limited alternative resources hinder AMHP practice (Kinney, 2009) and their requirement for impartiality.

AMHPs openly detailed how resource problems are endemic across all local authorities, influencing AMHP autonomy and independent decision-making along with their obligation to consider social perspectives in the MHA assessment context (Hall, 2017). My analysis reveals that besides this lack of resources affecting professional decision-making and day-to-day experiences of risk work, it creates a “revolving door syndrome” for Black service users already overwhelmed by disadvantages within the mental health system.

7.8 Evidence of epistemic injustice in decisions relating to detention

7.8.1 Black service users' experiences of epistemic injustice

Using Fricker's theory of epistemic injustice (Fricker, 2007) and its interrelated concepts, I analyse my findings to advance understanding of the specificities of Black service users' detention experiences and whether professionals account for their knowledge, circumstances, and experiences when developing their judgements. Participants' accounts confirm how epistemic injustice partially stems from the epistemic privilege professionals enjoy during the MHA assessment process. Practitioners enjoy this status through their training, expertise, and objective data to "occupy the epistemically privileged role" (Carel and Kidd, 2016, p.16) of assessing risk and evaluating whose testimonies and knowledge are worthy of epistemic consideration. The observational data presents professionals as "epistemically privileged" through their decision-making and occupying authoritative roles in epistemic interchanges, holding power over which testimonies to receive and whether the views of service users and their relatives/carers matter during detention decisions. The AMHPs regularly defer to biomedical knowledge, with little regard for the opinions of the service user or their carer.

The AMHPs describe how their decision-maker role coupled with their power to detain individuals following MHA assessments privilege them during epistemic conversation. Service users expect to be told the outcome of the risk assessment by AMHPs, but in contrast, AMHPs are not expected to be informed by the service user about the outcome. There is a power inequality in the relationship between an AMHP and a service user because of the inherent hierarchy ascribing to the professional an elevated epistemic status and widely recognised social position (Carel and Kidd, 2014).

Professionals and service users can be “epistemically privileged” for various reasons, but only professional status matters during the risk assessment and detention decisions. A service user’s knowledge is commonly restricted to the “private realm” (Carel and Kidd, 2014, p.16) and discounted during detention decisions, risk interventions, and treatment plans. Participants describe how professional knowledge - particularly from consultants - is privileged over the views and wishes of service users and their families and absent of professional scrutiny. Epistemic privilege is a subtler form of epistemic injustice relating to the disparity between Black service users’ and professionals’ perspectives of mental illness and risk, which is highlighted in the exchanges during the MHA assessment.

During the MHA assessment process, unequal power dynamics and the relational aspects of detention limit service users’ epistemic agency. Black service users describe how professional power manifests in practice, with large numbers of professionals - including police officers - overawing service users, making them silent and muting their experiences. This partly reinforces an earlier study highlighting how professional power operates in ward meetings where large numbers of professionals appeared to damage the epistemic agency of service users, rendering them powerless to challenge professional assumptions (Newbigging and Ridley, 2018). Participants referenced coercion, physical restraint, and the unpleasantly “crude way” of administering medication during hospital detention, with these earlier inhumane and punitive treatment experiences often deterring them from speaking up and consequently restraining their voices. While both white and Black service users are subject to these forms of pharmacological restraint, Black service users are disproportionately affected and tend to be offered higher doses of antipsychotics (DHSC, 2019c). For those from Black communities in particular, this constrains their epistemic agency, creating considerable fear and mistrust of services (Keating and Robinson, 2004). In this context, I argue that Black service users' experiences are analogous to what Dotson (2011, p. 245) terms "testimonial smothering", a type of "coerced silencing" whereby a person withholds their testimony fearing ramifications or negative effects. Consequently, Black service users' earlier experiences of "punitive treatments" regulate their epistemic agency and deter them from communicating information.

Black service users report how involuntary admission limits their ability to exercise their rights or articulate concerns. For some, earlier unsuccessful appeals and disempowerment by professionals overlooking their complaints and disregarding their views and choices undermines their willingness and capacity to challenge any subsequent decisions perceived as unfair. Service users believe professionals hold concealed agendas with little opportunity to challenge decisions and inaccurate information. This resonates with findings from the literature suggesting service users perceived concealed professional agendas and lacked ways to challenge professional assumptions about them (Newbigging and Ridley, 2018).

Despite some service users describing the safe and secure feeling provided by hospital admission, the most frequent accounts depict detention as inhumane, disabling, terrifying, and disempowering, with the difficulty of finding your voice in a punitive environment described as "worse than serving a prison sentence"*.* Participants describe how professional power operates within the mental health system, with the paternalistic culture developed by practitioners excluding service users from decisions related to their lives under the guise of risk management. Service users often become the object of epistemic risk practices rather than participants within them (Newbigging and Ridley, 2018) demonstrating how Black users were completely denied roles as contributing epistemic agents (Hookway, 2010). This study presents service users and their families as excluded from decision-making about risk, undermined as knowers and participants during epistemic efforts to formulate decisions over whether to admit them to the hospital for assessment and/or treatment. Several AMHPs describe consistently making decisions profoundly impacting the lives of the vulnerable individuals undergoing assessment without ascertaining or respecting their views and preferences. Further evidence saw service users excluded by professionals from decision-making processes lacking comprehension of their experiences and narratives. Participants report service users' deep concerns over not being heard by professionals whose judgements were formed by assumptions and prejudicial stereotypes.

The observational and interview data reveal elements of Fricker's testimonial injustice (2007), with participants describing how their accounts and testimonies were discounted or dismissed due to their mental illness and race. This was demonstrated in the account of a Black service user being afforded lower credibility by being Black and possessing a mental health condition often associated with delusions and irrationality (Sanati and Kyratsous, 2015). The professionals assessing the service user believed his testimony to be an extension of his psychotic condition, revealing a prejudice based on negative stereotypes associated with his social and cultural identity. Consequently, the professionals overlooked crucial information about his culture and identity which might have rationalised his behaviour.

The stigmatisation and negative experiences Black people with mental health difficulties endure in the community - including becoming victims of anti-social behaviour - were often dismissed during the referral and assessment process. When Black service users raise valid complaints to professionals or express reasonable concerns over issues relating to their neighbours or the general public, their accounts are often dismissed as mere symptoms of their mental disorder. This reflects earlier evidence that preconceived ideas of irrationality and cognitive impairment are frequently projected onto people experiencing serious mental health issues, leading to serious errors in MHA assessments due to epistemic inaccuracies (Molas, 2016).

Through experiences of Black service users who have been detained and their level of involvement in decisions about their care and treatment, their accounts powerfully demonstrate what Fricker (2007, p. 28) terms an “identity-prejudicial credibility deficit”. This describes how a person’s testimony is afforded lower integrity due to prejudice related to their social identity. One Black male service user explains how his testimony to a clinician of being violently attacked by eight or nine police officers was dismissed due to prejudice towards him as a young “Black male”. This service user suffered unmerited discrimination as his identity, race, and gender should be irrelevant to determining his credibility. He alludes to negative stereotypes attached to Black men as being dangerous, which partly accounts for the clinician’s denigration of his experience or knowledge. This reinforces what it means to be a Black man; his account describes how the only ‘plausible’ story is that he is violent leaving no space for him to be a victim because his role as aggressor is so cemented. Risk produces epistemic injustice which unavoidably affects Black people, as once a person is categorised as risky, their status as a knower is destroyed. The credibility deficit caused by identity prejudice overwhelms and suppresses other narratives, with professionals centring on the dominant prejudicial stories associated with a social identity. In this instance, there was a lack of understanding of the context, his vulnerability, and his fear, and an absence of alternative framings of his experience.

Another example of testimonial injustice was illustrated by a Black service user describing his experience of police and mental health professionals disbelieving him because of his race and mental illness diagnosis. As per his account, he suffered racial and epistemic discrimination during his unwarranted arrest and subsequent detention. Professionals conferred disproportionately high credibility to his partner's account because of her status as a white middle-class female nurse, while his explanation was devalued because of his race. Fricker (2007) terms this a “credibility deficit” generated by negative stereotypes associated with his racial group. Previous studies have identified that individuals suffering from physical health conditions can be vulnerable to epistemic injustice (Carel and Kidd, 2014), and those experiencing serious mental health conditions are even more susceptible (Crichton *et al.*, 2016). This study further ascertains how epistemic/testimonial injustice manifests within mental health services, revealing how Black service users are more vulnerable to epistemic injustice than their white counterparts because of the double stigmatisation (Wilkinson 1998) or stereotyping received by being Black and possessing a mental disorder diagnosis.

Detention predisposes Black service users to ill-treatment and a sense of dehumanisation (Newbigging and Ridley, 2018). Participants frequently recognise the stigma attached to their mental illness and the inhumane treatment delivered by mental health professionals attaching little value to their voices or opinions. Following detention, some Black service users describe not being treated “like a normal human being any more”. This partially reaffirms the literature reporting Black service users “being abusively identified as inhuman or animalistic” (Solanki 2020, p. 92).

7.8.2 Black professionals' experiences of epistemic injustice

This study reveals how several AMHPs from Black backgrounds experienced testimonial injustice from white colleagues disregarding their knowledge and competency owing to prejudice over their social identity. While talking with a Black female AMHP about her experience of working with service users from Black communities, she alludes to institutional racism within the mental health system, with Black people - including professionals and service users - suffering discrimination and being treated as less capable. Unconscious epistemic bias and institutional racism within the system leave Black people, including professionals, having to "work doubly hard" for the same epistemic status as white colleagues during testimonial exchanges. My observational data presents AMHPs describing doctors devaluing their integrity and "looking down on Black social workers" and their legal interpretations. This evidence concurs with Collins's (2000, p. 69) assertion that Black women are less likely to be considered competent because of a failure to recognise their credibility beyond stigmatising ‘‘controlling images’’. These accounts by Black AMHPs suggest that they are systematically undervalued as knowledge holders and considered less competent due to negative stereotypes associated with their racial identity.

Although testimonial injustice is commonplace in participants' accounts, several experienced practitioners demonstrate incorporating corrective measures into their practice amid a culture of blame. A particularly striking example originated from Mary - an AMHP of twelve years – of a consultant at the expected discharge of a patient following the culmination of the Section 2 assessment period. The doctor requested she apply for Section 3 so that the Black service user could be monitored under CTO upon discharge. This AMHP felt further applications for compulsory detention were unreasonable because the user had made progress during the assessment period, but the doctor feared him relapsing in the community and presenting a risk to others. Mary recounts that when she refused to apply for Section 3, she received overwhelming pressure from her managers and fellow colleagues to reconsider, but she “stuck to her gun”.

7.9 Explanatory power of the theoretical framework – risk work and epistemic injustice

By combining the concepts of risk work (Brown and Gale, 2018) and epistemic injustice (Fricker, 2007) into a single framework for exploring AMHP detention decisions, I hoped to discover whether this integrative theoretical context could further our understanding of how and why Black people are disproportionally assessed under the MHA. In light of the evidence generated by this research, this theoretical framework offers powerful explanations for AMHP decision-making. This conceptualisation of risk work coupled with epistemic injustice presents an innovative and wide-ranging basis for analysing AMHP detention decisions over Black people during assessments.

The risk work (Brown and Gale, 2018) component of this integrative framework generates interpretations of how AMHPs apply their knowledge of different types of risk into specific contexts while engaging in communication exchanges, interacting with Black service users, and identifying risk interventions. This contextualises how

AMHPs make detention decisions reliant on risk to the detriment of their role and professional autonomy, and the implication for Black service user experience.

The empirical findings show moral features embedded in risk work for holding professionals accountable, with tensions generated by how AMHPs manage this. The uncertainty associated with mental illness, professional anxiety, and perception of risk associated with Black service users within a 'blame culture' create risk-averse and defensive practices. AMHPs' mishandling of risk and detention decisions harm trust and client relationships, causing suspicion and disengagement in Black service users. Consequently, the framework's risk work aspect provides a window into AMHP practice by helping explain the tensions in their everyday work, where risk management and procedural protocol-driven practices for minimising risk paradoxically fuel mistrust of services, undermining cooperation and leaving service users susceptible to defensive approaches and interventions. By contextualising AMHP risk assessments and decision-making and the complex dynamics within the multiagency working environment, we can identify how AMHPs' handling and management of risk is socially constructed within a biomedical model dictating the parameters of MHA assessments and any consequent decision-making, at the expense of their professional imperative to utilise social perspectives.

The research presents a preoccupation with risk that unquestionably affects detention decisions over Black service users, which coupled with epistemic injustice provides a method of application in practice-informed studies about the AMHP profession (Stanley, 2018). For example, if there is a conflict between a practitioner and a service user when interpreting a particular behaviour, how can a practitioner engage social work values/ideals for sharing knowledge production with the service user?

As another dimension of the theoretical framework, epistemic injustice (Fricker, 2007) detects the power asymmetries in mental healthcare privileging professional authority and knowledge over lived experience, the injustice and denigration of expertise in particular social groups owing to prejudices about their social identity, and the ethnic inequalities in service experience. This illuminates the powerful processes mobilising racism in the name of risk which is critical for providing an understanding of the unequal power dynamics embedded in MHA assessments, along with offering insights into Black service users' accounts of detention and interactions with social workers/AMHPs engaged in risk work.

Theorising AMHP decision-making in terms of epistemic injustice provides an analysis of the unequal relationship between professionals and marginalised service users, whereby practitioners rely solely on their knowledge and interpretations of what is perceived as 'risky' to make risk interventions profoundly impacting individuals undergoing MHA assessment. This aspect of the integrative theoretical framework illustrates how professionals formulate risk judgements over Black people, their social status in the context of interaction and relationships, their level of participation in epistemic practices, and who is considered knowledgeable because of their identity or social position during the assessment process. The generated themes present different forms of epistemic injustice occurring, with evidence of Black service users being considered less competent and excluded from their care and treatment decisions because of their social identity. Black service users' accounts powerfully depict what Fricker (2007, p. 28) terms an "identity-prejudicial credibility deficit", whereby a person's testimony is afforded lesser credibility because of prejudicial attitudes towards their social identity.

This integrative theoretical framework was a useful tool for answering my research questions and interpreting data, revealing the dynamics operating within MHA assessments and illuminating the complex relationships between risk and epistemic injustice. The framework details risk dominates professional thinking constructing epistemic injustice, so that if risk is present so is epistemic injustice, and if epistemic injustice is present so is racism. Risk renders Black people – including professionals – as unknowledgeable; cementing high-risk categorisations to the Black experiences. Consequently, risk produces epistemic injustice towards Black people by professionally classifying them as risky, and destroying their status as knowledge producers.

This theoretical framework raises fundamental questions about what can be done to balance the social and medical models, and whether the AMHP profession is a solution for the unjust and discriminatory practices identified within MHA assessments. It provides a way to address tensions in client-facing risk work through ‘listeners’ - AMHPs and other professionals involved in assessments - making conscious efforts to offer greater credibility to service users enabling what Fricker (2007, Pg.1) terms “testimonial justice”. This broadens our understanding of Black service users' detention experiences, as well as evaluating whether professionals respect the knowledge and circumstances of service users.

7.10 Methodological strengths and limitations

This qualitative research is distinct in its examination of how AMHPs utilise their knowledge of the MHA and risk - including their implicit knowledge - to interpret behaviour or phenomena when making judgements about whether an individual undergoing MHA assessment should be detained. It also highlights the experiences of Black service users who are disproportionately affected by MHA assessments and AMHPs' detention decisions. The critical analysis of the literature about AMHP decision-making revealed a dearth of direct observational studies into how practitioners form detention judgments or how interactions take place between practitioners and Black service users. Previous academic research exploring the AMHP role is inexact (Stone, 2019; Hall, 2017; Abbott, 2018; Brammer, 2020) and lacks direct observational data of actual practice, uncritically accepting self-reported behaviour and normative perspectives. This discussion chapter presents how this study's qualitative approach successfully explores the overarching research question about AMHPs' detention decisions over Black people and the primary influences shaping their judgements.

This methodological approach offers a detailed examination and description of the quality of people's experiences (Marvasti, 2004), strengthening the voices of those facing social exclusion including Black and ethnic minority people previously emphasised by Humphries (2008). This was achieved by considering the perspectives of users in the research and collecting ethnographic data to effectively understand how AMHPs make detention decisions, observing what practitioners do rather than what they report they do. Witnessing AMHPs' in-person interactions with Black service users displayed the dynamics of conversations, revealing experiences that otherwise would be left uncaptured (Longhofer and Floersch, 2012), which Ferguson (2016, p.156) explains "can provide even deeper insights into what is done and experienced, as well as what is said in practice". Observing practitioner's everyday practices and face-to-face encounters with service users allows us to see the unremarkable features of people's practices that escape narrative accounts (Bisaillon and Rankin, 2012).

The literature review presented most AMHP practices occurring away from public scrutiny and independent appraisal, so this current study helps bridge this gap. The methodological flexibility of ethnography was a strength in this research providing direct observation of the actual practice of assessing Black people for compulsory admission. The role of the AMHP in conducting MHA assessments and making detention decisions within a fast-paced environment is complex, so being present to observe events unfolding allowed me to capture and grasp the nuances.

As discussed in the methods chapter, immersing myself in an AMHP team allowed me to scrutinise the formal and informal processes involved when assessing people for involuntary hospital admissions. Establishing rapport and relationships over time with participants allowed me access to less discernible events while creating space to explore thought processes and the emotional aspects of their work (O’Connor, 2020). The role of the insider researcher should be seen or acknowledged as a potential advantage or disadvantage in a study. My close relationship with the AMHPs enabled their open interaction to freely discuss their cases in my presence, and the gut feelings informing their decisions. However, I deliberately engaged in reflexivity, carefully managing my relationships with AMHPs in case this familiarity bred over-rapport (Hoolachan, 2019) losing the analytical distance required for qualitative research.

My research also identifies racism in MHA assessments and prejudicial attitudes from professionals disadvantaging Black people that are difficult to identify without conducting detailed observational work. By using ethnography to examine face-to-face encounters between professionals and Black service users, we can see the unequal power dynamics and professional mindsets directed towards certain social groups.

Similarly, this research provides rich qualitative data about AMHPs' decision-making and Black service users' lived experiences of detention in contrast with the prevalence of quantitative data. My study highlights how Black people experience AMHP detention decisions, which prior literature identifies as neglected in wider service user movements (Wallcraft *et al.*, 2003; Solanki, 2020).

One of this study's methodological strengths is the contribution of Black service users, amplifying the voices of people under assessment and exploring the gulf between practitioner and service user perceptions of risk, treatment, and care. While the ethical implications of involving vulnerable service users in ethnographic research have been debated (Abbott, 2018), this study joins Ferguson's (2016) work depicting how a researcher can examine encounters in intimate places - such as service users' homes - without harming people or practice.

The research adopted purposive sampling to select potential participants across the two sites. While this is considered one of the most effective and commonly used techniques in qualitative research (Carey, 2012), its potential for "generalising to the population" (Keating and Robertson, 2004, p,441) may be limited; however, the knowledge and insight acquired may be transferrable in different settings (Morse, 1999). The sample's diversity helped capture the nuances and issues Black service users encounter during the detention process, and contextualise the differing perspectives of the study's participants. Despite these strengths, I identified certain limitations to my research methodology.

My research focuses on the AMHP role - as opposed to the other professionals involved in the MHA assessment – because of its supposed discretionary powers over detention decision-making and the specific functions they discharge. However, doctors and clinicians continue to wield considerable power within the multi-disciplinary setting as a consequence of the prevalence of risk and the medical model, with medical recommendations setting the tone for MHA assessments and detention decisions. Future research studies should seek to incorporate the perspectives of medical professionals - including clinicians - to generate complementary information about decisions regarding the involuntary admission of Black service users.

The transferability of qualitative findings from one context to another can be a drawback. Nevertheless, by utilising Lincoln and Guba (1985) and Nowell *et al.* (2017), I have sought to practice transparency when gathering and analysing data, noting the contextual elements, timelines, and research process for ensuring dependability and credibility for grounding claims of generalisability in similar research settings. Voluminous data was garnered from observations, fieldnotes, and interviews, and the limited space available for presenting these findings necessitated both selectiveness and the construction of succinct data extracts.

The purpose of the study was to examine AMHP decision-making and its consequences for Black service users, so I disregarded service users from the majority white population. While focusing solely on Black service users assisted the exploration of the issues of race and ethnicity highlighted by the literature, it presented a disadvantage because involving other social groups could facilitate a comparative analysis with the potential for greater understanding. This may be an interesting area for future research studies.

My research began in the middle of the COVID pandemic, affecting office-based work. As noted in the methods chapter, participants at research Site 2 worked remotely except for during MHA assessments which occurred in person. This meant I joined their virtual allocation meetings in the mornings, observing their discussions of various referrals, and the allocation of cases to practitioners. Although I witnessed several interesting conversations among the practitioners, I did not feel that same sense of immersion or presence as I did at Site 1 with its in-person meetings in an office-based environment. Furthermore, most of the participants at Site 2 turned off their cameras during the virtual meetings making it impossible to observe their body language which functions as an important element of ethnography. However, this limitation did not significantly affect the study data, because this team was kept as a secondary Site.

This research is unique and original by interlacing the three dimensions of my methodological approach, my data and methods of collection and analysis, and the novel combination of the two distinct concepts of risk work and epistemic injustice into a theoretical framework.

7.10.1 Future research

These findings establish the necessity of further research specifically focused on AMHP autonomy and their specific purpose to represent social perspectives. This is crucial for answering critical questions about balancing the social and medical models, and whether the AMHP profession is the solution for unjust and discriminatory practices within MHA assessments.

My research demonstrates a case for further study into the influence of referrals made by Black parents and carers on professional conceptualisations of risk. This study has revealed that professionals assign high-risk status to the decision of Black parents to initiate a referral or call the police on their young Black sons.

Additionally, another research area should involve a detailed study and comparative analysis of Black and white service users' experiences of risk assessment and detention under the MHA. This will hopefully clarify whether professionals apply differing risk thresholds or interpret legislation around the specific social identity of the person undergoing assessment.

7.11 Implications for policy and practice

This research connects the theoretical area of risk work with applied - and potentially impactful - frontline practice. The literature has shown a dearth of direct observational studies into the actual practice of assessing Black service users for compulsory admission for treatment. This study illuminates how approved mental health professionals practically use compulsory powers, contributing to the knowledge base for resolving longstanding policy concerns over mental health inequalities for Black service users. These findings contribute to an ongoing dialogue around the experiences of marginalised groups within the mental health system - specifically young Black men who continue to be defined as high-risk, perceived as threats to public safety, and excluded from decision-making over their care and treatment. The recommendations gleaned from these findings will hopefully advance a good practice model and evidence-based ways to address inequalities in person-centred social care.

This may similarly improve AMHP practice, making it more ethical, empowering, and beneficial to Black service users and those from other ethnic groups.

Integrating risk work and epistemic injustice concepts into a research framework adds a new dimension to risk literature by depicting the epistemic practices underpinning the translation of risk knowledge and social relations within the client-facing risk work context. This study presents a symbiotic relationship between risk and epistemic injustice during MHA assessments for marginalised groups, with risk functioning as a cover story for the suppression of marginalised voices, social justice, and human rights of both Black people and other groups. Risk trumps everything via its supporting political and media discourses, so much so that deploying a high-risk narrative subdues social perspectives, user involvement or participation, and all discussion of rights.

Previous studies have argued that individuals suffering from physical health conditions are vulnerable to epistemic injustice (Carel and Kidd, 2014), with those experiencing serious mental health conditions even more susceptible (Crichton *et al.*, 2016). This study demonstrates how epistemic/testimonial injustice manifests within the mental health service, with Black service users even more vulnerable to epistemic injustice than their white counterparts owing to the dual stigmas (Wilkinson 1998) of being Black and having a mental disorder diagnosis. Coupled with the racialised categorisation of risk and inequalities in diagnostic practices and service experience, this presents broad implications for policy initiatives and the development of tangible strategic actions to drive positive change and outcomes at all levels. Additionally, there are obvious moral and ethical implications for AMHP practice, with legitimate questions emerging from this research about the status of their professional imperative to apply social perspectives, and their commitment to promoting social justice and the human rights of these vulnerable individuals. I have argued that if mental health professionals - legally obligated to conduct MHA assessments, championing social justice and human rights - continue to hold prejudicial attitudes towards specific social groups such as young Black men, how can they make accurate detention decisions grounded in fair risk assessments? Unless the discriminatory and prejudicial attitudes evidenced in this study are confronted head-on and an alternative framing of Black service users' experiences, knowledge, and preferences are considered during MHA assessments, the longstanding ethnic inequalities in mental healthcare experience will persist.

This study demonstrates how AMHPs’ discretionary power to make independent decisions and challenge aspects of the law that discriminate against certain social groups is limited by the multiagency working environment, managerialism, resource depletion, and ‘blame culture’. According to the findings, most AMHPs were unable to confront injustices against Black people in particular, because this requires challenging not just doctors or other mental health professionals but the entire architecture of clinical managerial practice. This questions the purpose and future of AMHP practice, and their requirement to serve as ‘independent arbiters’ championing service user rights, maintaining an independent perspective counterbalancing the medical model (Knott and Bannigan, 2013; Hall, 2017). Future policy development concerning ways to enhance AMHP practice should account for power dynamics within the multiagency working environment alongside organisational factors and risk management practices that constrain the capacity of AMHPs to work in the best interests of marginalised service user groups, while also ensuring effective management of mental health risks.

In this chapter, we discussed how participants emphasised various ways of improving epistemic justice. This included the supportive role of independent mental health advocates in enabling individuals to express themselves and present an alternative framing of service users' accounts and experiences during the MHA assessment process, particularly in the community. The study also supports the position that professionals who listen to and respect the preferences and choices of service users, instead of assuming they know best, may reduce the stigma, sense of exclusion, and diminished control and choice experienced by all people with mental health problems, and especially those from Black backgrounds.

In my research, I found the current arrangement - whereby the IMHA service is only accessible to service users detained or under CTO - as not suitable. It would be more practicable and beneficial to Black service users to have access to this service during MHA assessments in the community to help promote epistemic justice. Thus, access to IMHA services needs to be expanded and made available during the MHA assessment, both in the hospital and in the community.

7.12 Conclusion

In this study, I adopted an ethnographic approach to explore how AMHPs make decisions about compulsory admission, particularly concerning Black people who are four times more likely to be detained under the MHA. I incorporated concepts of risk work and epistemic injustice into my theoretical framework to examine detention decisions and to determine if the framework can provide insight into the disproportionate assessment of Black people. The data and the findings of this study have demonstrated that my integrated theoretical framework has been a valuable tool, shedding light on the complex relationship between risk and epistemic injustice influencing AMHP decisions relating to Black people.

The ethnographic methodology provided a valuable method of observing professionals' direct interactions and face-to-face encounters with Black service users. This enabled me to see what professionals do in areas of their practices that are overlooked and less amenable to storytelling. This study has unravelled some of the key influences driving detention decisions, contributing to our understanding and helping to resolve longstanding policy concerns about health inequalities for Black service users who are overrepresented within the mental health system. My analysis revealed how professionals applied comparatively lower risk thresholds for Black service users, resulting in significantly more use of the MHA. The study demonstrates how risk and ethnicity maintain a mutually constitutive relationship in detention decision-making. It also revealed the racialised categorisation of risk and how professionals' decision-making continues to be shaped by risk and public safety agendas. This dynamic highlights professionals' perceptions of dangerousness or 'risk to others' as disproportionately attributed to Black people, reflecting a persistent tendency to view them predominantly as a threat to the public rather than as individuals at risk of harm themselves. Such framing overlooks their preferences, experiences, and social circumstances, constituting a form of epistemic injustice. The study demonstrates that racism in MHA assessments, prejudicial attitudes of professionals towards Black people, and the processes producing the disproportionality are difficult to identify without conducting detailed observational work. By examining face-to-face encounters between professionals and Black service users, the unequal power dynamics and professionals' attitudes toward these social groups become visible. My analysis also indicates that risks were mitigated or intensified differently depending on a service user's race and ethnicity, particularly related to a community's experience of police brutality.

The study’s findings illustrate how ubiquitous paradoxical risk management practices are in MHA assessments. It highlights that although AMHPs recognised the importance of these practices for ensuring the safety of Black service users, they also noted that the increasing paperwork and bureaucratic processes associated with MHA assessments impacted their daily practices and decision-making. These organisational factors fuelled defensive practices due to fear of being held accountable for future negative outcomes. Professionals shared accounts of people losing their jobs and livelihoods for not adhering to risk management measures, adding pressure on AMHPs and having implications for their detention decision-making over Black service users.

Furthermore, my research demonstrates that even Black AMHPs reinforce racism in the mental health system. This is because they lack autonomy and the ability to exercise their discretion and fully implement social perspectives due to their reliance on traditional medical narratives and risk-focused language during detention decisions, which disproportionately affect Black people. While Black professionals may demonstrate empathy, they struggle to utilise social models in their practice and to challenge racism and the discriminatory aspects of the law impacting Black people.

The research indicates that most practitioners doubt their ability to exercise independent decisions within the context of multiagency working while dealing with organisational factors, resource implications, the dominance of risk, and ‘blame culture’. The autonomy of AMHPs is often judged according to their willingness to take risks when medical professionals are reluctant to do so. However, my ethnographic study revealed that in real-life situations, AMHPs often choose the easier option by aligning with medical opinions to detain the assessed person. This contradicts their professional obligation to exercise their discretion and consider social perspectives

(Hemmington, 2023). The findings of this study shed light on how frontline risk work is potentially undermining the autonomy of AMHP while fortifying the dominance of other professional groups, such as clinicians, involved in the MHA risk assessment. This finding is significant for understanding the impact of risk on power dynamics between professional groups responsible for decision-making over the compulsory admission of Black service users.

I argue that the inability of AMHPs to exercise their discretion and apply social perspectives in their decision-making can significantly impact Black service users, According to the literature, these users are often confronted with multiple social issues or disadvantages such as isolation, unemployment, marginalisation, low income, and social exclusion (Campbell, 2010).

Moreover, this thesis has demonstrated that Black individuals in mental health services experience epistemic injustice during detention. The research has emphasised that the focus on risk in MHA assessments, along with AMHPs relying heavily on biomedical knowledge, disregards the social context and real-life circumstances of people's lives. The concept of risk creates epistemic injustice and their lack of recognition of knowledge producers, which disproportionately affects Black people. When professionals categorise someone as risky, it undermines their credibility as a knower. Accounts from service users illustrate how racial discrimination, the "identity-prejudicial credibility deficit" (Fricker, 2007, p. 28), and the loss of status contribute to their experiences of detention and the pathways into the mental health system. Instead of being active participants, they are often treated as objects of epistemic practices of risk (Newbigging and Ridley, 2018). The study's findings shed light on how epistemic/testimonial injustice manifests within mental health services for Black people compared to their white counterparts. This is due to the intersecting stigmas and negative stereotypes they experience as a result of both their race and mental health diagnosis. Crucially, the study also discovered that some AMHPs from Black backgrounds experience testimonial injustice from their white colleagues. This injustice involves their knowledge and competence being given less credibility due to prejudice based on their social identity.

In this study, I have highlighted the importance of considering participants' perspectives on the various ways of enhancing epistemic justice. This includes recognising the facilitative role played by independent mental health advocates in empowering individuals to express themselves and advocating for alternative framings of the experiences of Black service users undergoing the MHA assessment process in the community. My research also reinforces the argument that professionals actively listening and respecting the preferences and choices of service users instead of knowing best will help reduce the stigma, sense of exclusion, and diminished control experienced by people with mental health issues, particularly those from Black communities.

References

Abbott, S. (2018) "*Using the Law in Social Work Approved Mental Health Professional Practice*." DSW diss., University of Sussex.

Adebowale, V. (2013) *The Independent Commission on Mental Health and Policing report.* London: Independent Commission on Mental Health and Policing.

Allen, R., Carr, S., Linde, K. and Sewell, H. (2016) *Social Work for Better Mental Health: A Strategic Statement,* London, Department of Health.

Allen, R. (2014) The Role of the Social Worker in Adult Mental Health Services, *The College of Social Work.* Available online at: http://basw.co.uk/resources/role-social-worker-adult-mental-health-services.

Amit-Talal, V., (2000) Introduction: Constructing the Field. *In: V. Amit-Talal, ed, Constructing the Field: Ethnographic Fieldwork in the Contemporary World*. London: Routledge, pp. 1-18.

Ashencaen Crabtree, S. (2013) 'Research ethics and the moral enterprise of ethnography: Conjunctions and contradictions', *Ethics and Social Welfare*, 7(4), pp. 359 – 78.

Atkinson, P. (2017) *Thinking Ethnographically*. London: Sage.

Atkinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland, L. (2007) *Handbook of Ethnography*. London: Sage.

Atkinson, P., Coffey, A., Delamont, S., et al., 2001 (reprinted 2008) *Editorial Introduction. In: P. Atkinson, A. Coffey, S. Delamont, J. et al, eds, Handbook of Ethnography*. London: Sage Publications, pp. 1-7.

Aven, T., & Renn, O. (2010) Risk management and governance: concepts, guidelines and applications (Vol. 16). *Springer Science & Business Media.*

Barber, P., Brown, R., Martin, D. (2012) *Mental Health Law in England and Wales: A Guide for Mental Health Professionals*. 2nd edition. London. Sage.

Barnes, M., Bowl, R. and Fisher, M. (1990) *Sectioned: Social Services and the 1983 Mental Health Act,* London: Routledge.

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., & Smith, S. (2019) Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, Vol 6, 305–317. Elsevier.

Bartlett, P. (2010) Civil confinement. In L. Gostin, J. McHale, P. Fennell, R. D. Mackay, & P. Bartlett (Eds.), *Principles of mental health law and policy*. Oxford: Oxford University Press (at para 12.19).

Basit, T. N. (2013) Ethics, reflexivity, and access in educational research: Issues in intergenerational investigation*. Research Papers in Education, 28(4), 506–517.*

BASW (2021) *The BASW Code of Ethics for Social Work*. Birmingham: BASW.

Basset, T. and Stickley, T. (eds.) (2010) Voices of Experience: Narratives of Mental Health Survivors, Chichester, England, *John Wiley and Sons.*

Beck, U. (1992) *Risk society: Towards a new modernity*. London: SAGE Publications.

Beddoe, L. (2010) Surveillance or reflection: Professional supervision in 'the risk society'. *British Journal of Social Work*, 40(4), 1279–1296.

Beresford, P., Russo, J. (2016) Supporting the sustainability of Mad Studies and preventing its co-option. Disabil. Soc. 31 (2), 270–274.

Berger, R. (2013) Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. Qualitative Research, 15(2), 219–234.

Bhui, K., Halvorsrud, K. and Nazroo, J. (2018) Making a difference: Ethnic inequality and severe mental illness. *The British Journal of Psychiatry: The Journal of Mental Science*, 213(4), 574-578.

Bhui, K., and O'Hara, J. (2014) Ethnic inequalities, complexity and social exclusion. In S. C. Davies (Ed.), Annual report of the Chief Medical Officer 2013. Public mental health priorities: Investing in evidence (pp. 276–284). London, UK: Department of Health.

Bhui, K. (2001) Over-representation of Black people in secure psychiatric facilities. *British Journal Psychiatry, 178 (6) 575.*

Bhui, K. (2001) *Racism and mental health: Prejudice and suffering*. London: Jessica Kingsley Publishers.

Bignall, T. Jeraj, S., Helsby, E., & Butt, J. (2019) *Racial disparities in mental health: Literature and evidence review. Race Equality Foundation.*

Bindman, J., Beck, A., Thornicroft, G., Knapp, M. and Szmukler, G. (2000) Psychiatry patients at greatest risk and in greatest need: impact of the supervision register policy. *British Journal of Psychiatry*, 177, 33-7.

Bisaillon, L. and Rankin, J. (2012) *Navigating the Politics of Fieldwork Using Institutional Ethnography: Strategies for Practice [64 paragraphs]. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 14(1), Art.14,* http://nbn-resolving.de/urn:nbn:de:0114- fqs1301144 (Accessed 15.06.2022).

Boahen, G. F. (2014) *Ethnicity, learning disability, and the Mental Capacity Act 2005: a social constructionist ethnography of an integrated learning disability service*. PhD thesis The Open University.

Boardman, J. and Roberts, G. (2014) *Risk, Safety and Recovery, IMROC Briefing, Centre for Mental Health and Mental Health Network, NHS Confederation*. Available online at: http://centreformentalhealth.org.uk/publications/risk-safety and-recovery.

Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I. & Hughes, C. (2014) Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC medical research methodology*, 14(1), 42.

Bonnet, M. and Moran, N. (2020) Why Do Approved Mental Health Professionals Think Detentions under the Mental Health Act Are Rising and What Do They Think Should Be Done about It?, *The British Journal of Social Work,* Volume 50, Issue 2, March 2020, Pages 616–633, https://doi.org/10.1093/bjsw/bcaa001.

Bowen, P. (2007) *Blacktone's Guide to the Mental Health Act 2007*, New York, Oxford University Press.

Bradley, K. (2009) *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. London: Department of Health.

Brammer, Andrew (2020) A case study of the factors and processes involved in the use of compulsory powers when carrying out Mental Health Act 1983 (amended 2007) community assessments, from the perspectives of Approved Mental Health Professionals in one local authority in the North of England – A Critical Realist Perspective. Doctoral thesis, University of Huddersfield.

Braun, V. and Clarke, V. (2019) Reflecting on Reflexive Thematic Analysis. *Qualitative Research in Sport, Exercise and Health*. 11(4), 589-597.

Braun, V., Clarke, V., and Terry, G. (2015) Thematic analysis. In P. Rohleder and A. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 95–113). Basingstoke: Palgrave MacMillan.

Braun, V., and V. Clarke (2013) *Successful Qualitative Research: A Practical Guide for Beginners.* London: Sage.

Braun, V. and Clarke, V. (2006) "Using thematic analysis in psychology"*. Qualitative research in psychology.* 3(2): 77-101.

Brewer, J. (2012) 'Ethnography', in S. Becker, A. Bryman and H. Ferguson (eds), *Understanding Research for Social Policy and Social Work*, Bristol, Policy Press, pp. 302 – 11.

Brown, K. (2012) *Re-moralising 'vulnerability', People, Place & Policy* Online (2012): 6/1, pp. 41-53. DOI: 10.3351/ppp.0006.0001.0005.

Brown, R. (2016) *The Approved Mental Health Professional's Guide to Mental Health Law*. 4th Edition. London: Sage.

Brown, P. and Gale, N. (2018) Theorising risk work: Analysing professionals' lifeworlds and practices. *Professions & Professionalism, 8(1).*

Brown, P. and Gale, N. (2018) Developing a sociology of risk work in client-facing contexts: an editorial*, Health, Risk & Society, 20:1-2, 1-12, DOI: 10.1080/13698575.2018.1445072.*

Brown, P., & Calnan, M. (2013) Trust as a means of bridging the management of risk and the meeting of need: A case study in mental health service provision. *Social Policy &Administration, 47(3), 242–261. doi:10.1111/j.1467-9515.2012.00865.x*

Buchanan, M. (2021) *'Discriminatory' mental health system overhauled*. Available at: https://www.bbc.co.uk/news/health-55639104 (Accessed: 30 January 2021).

Buckland, R. (2016) The Decision by Approved Mental Health Professionals to Use Compulsory Powers under the Mental Health Act 1983: A Foucauldian Discourse Analysis. *British Journal of Social Work* 46 (1): 46–62. doi:10.1093/bjsw/bcu114.

Byskov, M. F. (2020) What Makes Epistemic Injustice an "Injustice"? *Journal of Social Philosophy*, Vol. 0 No. 0, Spring 2020, 1–18. DOI: 10.1111/josp.12348.

Brown, P., Calnan, M., Scrivener, A., and Szmukler, G. (2009) Trust in Mental Health Services: A neglected Concept. *Journal of Mental Health.* Vol. 18 Issue 5, p449-458

Bryman, L. (2015) *Social research methods*. 5th edition. New York: Oxford University Press.

Bryman, L. (2004) *Social research methods*. 2nd edition. New York: Oxford University Press.

Campbell, J. (2010) "Deciding to Detain: The Use of Compulsory Mental Health Law by UK Social Workers." *British Journal of Social Work 40 (1): 328–334*. doi:10.1093/bjsw/bcp121.

Campbell, J., Brophy, L., Healy, B. and O'Brien, A. M. (2006) International perspectives on the use of Community Treatment Orders: Implications for mental health social workers, *British Journal of Social Work, 36(7), pp. 1101 – 18.*

Campbell, J. and Davidson, G. (2009) Coercion in the Community: A Situated Approach to the Examination of Ethical Challenges for Mental Health Social Workers, *Ethics and Social Welfare*, 3(3), pp. 249–263.

Campbell, J., Wilson, G., Britton, F., Hamilton, B., Hughes, P. and Manktelow, R. (2001) The management and supervision of Approved Social Workers: Aspects of law, policy and practice, *The Journal of Social Welfare & Family Law, 23:2, 155-172, DOI: 10.1080/01418030122030.*

Care Quality Commission (2011) *Count me in census 2010*. London: CQC.

Care Quality Commission (2018) *Mental Health Act: The rise in the use of the MHA to detain people in English.* London: CQC.

Carel, H. H., and Kidd, I. J. (2014) Epistemic injustice in healthcare: a philosophical analysis. *Medicine, Health Care and Philosophy*, 17(4), 529-540. https://doi.org/10.1007/s11019-014-9560-2.

Carey, M. (2012) *Qualitative Research Skills for Social Work*: Theory and Practice. Farnham: Ashgate.

Carson, G. (2018) *Approved mental health professional numbers continue decline, Community Care finds. Community Care 14 February 2018*. Available from http://www.communitycare.co.uk/2018/02/14/approved-mental-health-professional-numbers-continue-decline-community-care-finds/ (Accessed 13/07/2018).

Cavadino, M. (1989) *Mental Health Law in Context: Doctor's Orders?* (Dartmouth Publishing Company) 12 (hereafter Cavadino, Doctor's Orders).

Charmaz, K. and Mitchell, R. (2001) Grounded Theory in Ethnography. In: Atkinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland, L. (eds.) *Handbook of Ethnography.* London, Sage, pp. 160-174.

Chiswick, D. (2012) 'Risk, rights and the mental health professional', *The British Journal of Psychiatry, 201(5*), pp. 349–350.

Chivers, C. (2018) What is the headspace they are in when they are making those referrals? Exploring the lifeworlds and experiences of health and social care practitioners undertaking risk work within the prevent strategy. *Health, Risk & Society*, 20(1). this issue.

Coffey, M., Cohen, R., Faulkner, A. Hannigan, B., Simpson, A., Barlow, S. (2017) Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations* Volume 20, Issue 3.

Coffey, M. and Hannigan, B. (2013) 'New roles for nurses as approved mental health professionals in England and Wales', *International Journal of Nursing Studies*, 50(10), pp. 1423–30.

Cohen, A., Patel, V., & Minas, H. (2014) A brief history of global mental health. In V. Patel, H. Minas, A. Cohen & M. J. Prince (Eds.), *Global mental health: Principles and practice* (pp. 3-26). Oxford University Press.

Collins, P. H. (2000) *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. 2nd ed. New York: Routledge.

Community care (2018) *Approved mental health professionals: pressures have never been greater.*

Cope, D. G. (2014) Methods and Meanings: Credibility and Trustworthiness of Qualitative Research. *Oncology Nursing Forum* 41(1), 89.

Costa, L., Voronka, J., Landry, D., Reid, J., McFarlane, B., Reville, D., & Church, K. (2012) Recovering our stories: A small act of resistance. *Studies in Social Justice*, 6(1), 85-101.

Crawford, M., Brown, B. and Boardman, J. (2019) *The Approved Mental Health Professional's Guide to Mental Health Law*. Exeter: Learning Matters.

Creswell, J. W., & Poth, C. N. (2018) *Qualitative inquiry and research design: Choosing among five approaches*. Sage.

Crichton, P., Carel, H. and Kidd, I. J. (2017) Epistemic injustice in psychiatry. *BJPsych Bulletin* 41, 65-70, doi: 10.1192/pb.bp.115.050682.

Cummins, I. (2015) Discussing race, racism and mental health: two mental health inquiries reconsidered. *International journal of Human Rights in Healthcare*, Vol. 8 Iss: 3, pp. 160-172.

Davidson, G. and Campbell, J. (2010) 'An audit of assessment and reporting by Approved Social Workers (ASWs)', *British Journal of Social Work*, 40(5), pp. 1609–27.

Davidson, G. and Campbell, J. (2007) 'An examination of the use of coercion by assertive outreach and community mental health teams in Northern Ireland', *British Journal of Social Work*, 37(3), pp. 537 – 55.

Davies, M. (2012) *Social work with adults*. Basingstoke: Palgrave Macmillan.

Davis, A. (1996) `Risk Work and Mental Health', in H. Kemshall and J. Pritchard (eds) *Good Practice in Risk Assessment and Risk Management*, Vol. 1. London: Jessica Kingsley.

Dawson, C. (2013) *Advance Research Methods: A `Practical Guide for Social Research Projects*. London: Constable and Robinson Ltd.

Dawson, J. and Szmukler, G. (2006) 'Fusion of mental health and incapacity legislation', *The British Journal of Psychiatry,* 188(6), pp. 504–509.

Denzin, N. K., Lincoln, Y. S (2018) *The Sage Handbook of Qualitative Research*. 5th Edition. London: Sage.

Department of Health and Social Care (2018) *Modernising the Mental Health Act Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983.* London.

Department of Health & Social Care (2019a) *Guidance for Clinical Commissioning Group and Local Authority partners on how to implement s140 MHA* 1983/2007. London.

Department of Health & Social Care (2019b) *National Workforce Plan for Approved Mental Health Professionals (AMHPs*). London.

Department of Health & Social Care (2019c) *Independent Review of the Mental Health Act 1983: supporting documents.* London.

Department of Health & Social Care (2021) *The Approved Mental Health Professional Workforce in the adult social care sector.* London.

Department of Health (2015) *Mental Health Act 1983: Code of Practice*. London, Department of Health.

Department of Health and Care Quality Commission (2016) *The effectiveness of the current approach to national monitoring of Approved Mental Health Professional Services, London: CQC and the Department of Health.* Available from https://s3-eu west-1.amazonaws.com/cjp-rbi-comcare/wp-con tent/uploads/sites/7/2016/04/CQC_DH_review. pdf (Accessed 13/07/2017).

Dohmen, J. (2016) "A Little Of Her Language": Epistemic Injustice And Mental Disability" *Res Philosophica*, Vol. 93, No. 4, October 2016, pp. 669–691 http://dx.doi.org/10.11612/resphil.1475.

Dotson, K. (2011) Tracking epistemic violence, tracking practices of silencing. *Hypatia* 26 (2), 236–257.

Douglas, M. (1990) Risk as a Forensic Resource. Daedalus, *Journal of the American Academy* 0/ Arts and Sciences, 119(4), pp. 1-16.

Douglas, M. (1994) *Risk and Blame: Essays in Cultural Theory*. London: Routledge

Emerson, R. M. (2009) *Ethnography, Interaction and Ordinary Trouble. Ethnography. 10(4), 535-548.*

Farre, A., Shaw, K., Heath, G., & Cummins, C. (2017) On doing 'risk work' in the context of successful outcomes: Exploring how medication safety is brought into action through health professionals' everyday working practices. *Health, Risk & Society*, 19(3–4), 209–225. doi:10.1080/13698575.2017.1336512

Fennell, P. (2007) *Mental Health: The New Law* (Jordans, Bristol 2007) 6.

Felton, A., Wright, N. and Stacey, G. (2017) ‘Therapeutic risk taking: A justifiable choice’, *British Journal of Psychiatry Advances*, 23(2), pp. 81–8.

Fernando, S. (2017) *Institutional racism in psychiatry and clinical psychology*. Hampshire: Palgrave Macmillan.

Fernando, S. (2010) *Mental health, race and culture. 3rd edition.* Basingstoke: Palgrave Macmillan.

Ferguson, H. (2016) Researching Social Work Practice Close Up: Using Ethnographic and Mobile Methods to Understand Encounters between Social Workers, Children and Families. *British Journal of Social Work*, 46, 153–168.

Finlay, L., & Gough, B. (2008) Reflexivity (1st ed.). *Wiley.*

Fistein, E.C., Clare, I.C.H., Redley, M., and Holland, A.J. (2016) Tension between policy and practice: A qualitative analysis of decisions regarding compulsory admission to psychiatric hospital. *International Journal of Law and Psychiatry*, 46, 50-57

Foucault, M. (1965) *Madness and Civilisation: A History of Insanity in the Age of Reason* (Richard Howard tr, Pantheon Books 1965) 46.

Fricker, M. (2006) Powerlessness and social interpretation. *Episteme* 3 (1–2), 96–108.

Fricker, M. (2007) *Epistemic Injustice: Power and The Ethics of Knowing*. Oxford University Press.

Frost, L., & Hoggett, P (2008). Human agency and social suffering. *Critical Social Policy*, *28*(4), 438-460.

Furminger, E. & Webber, M. (2009) The Effect of Crisis Resolution and Home Treatment on Assessments under the 1983 Mental Health Act: An Increased Workload for Approved Social Workers? *British Journal of Social Work,* 39(5), pp. 901-917.

Gale, N., Thomas, G., Thwaites, R., Greenfield, S., & Brown, P. (2016) Towards a sociology of risk work: A narrative review and synthesis. *Sociology Compass*, 10, 1046–1071. doi:10.1111/ soc4.12416

Geertz, C. (1973) *The interpretation of cultures: Selected essays*. New York, NY: Basic Books.

Gergen, K. J. (1985) The Social Constructionist Movement in Modern Psychology. *American Psychologist*. 40(3), 266.

Glover-Thomas, N. (2011) The Age of Risk: Risk Perception and Determination following the Mental Health Act 2007. *Medical Law Review* 19: 581–605.

Glover-Thomas, N (2018) Decision-Making Behaviour under the Mental Health Act 1983 and Its Impact on Mental Health Tribunals: An English Perspective.” *Laws* 7 (2)12: 12–23. doi:10.3390/laws7020012.

Golightley, M. (2014) *Social work and mental health*. Exeter: Learning Matters.

Gostin, L. (1975) *A Human Condition*, London: MIND.

Gregor, C. (2010) “Unconscious Aspects of Statutory Mental Health Social Work: Emotional Labour and the Approved Mental Health Professional.” *Journal of Social Work Practice* 24 (4): 429–443. doi:10.1080/02650531003791012.

Grote, G. (2015) Promoting safety by increasing uncertainty–Implications for risk management. *Safety Science, 71, 71-79.*

Grounds, A. (1995) Risk assessment and management in clinical context. In J. Crichton (ed.) *Psychiatric Patient Violence: Risk and Response* (London: Duckworth), pp. 43 – 59.

Guba, E.G. (1981) Criteria for assessing the trustworthiness of naturalistic inquiries, *Educational Communication and Technology Journal* 29, 75 - 91.

Hall, W. J., Chapman, M. V., Lee, K.M. et al (2015) Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *American Journal of Public Health* 105:e60–e76

Hall, P. (2017) Mental Health Act Assessments – Professional Narratives on Alternatives to Hospital Admission, *Journal of Social Work Practice*, 31:4, 445-459, DOI: 10.1080/02650533.2017.1394825

Hammersley, M. and Atkinson, P. (2007) *Ethnography: Principles in Practice*. 3rd edition. Milton Park: Routledge.

Harrits, G. S. (2016) Being professional and being human: Professionals’ sensemaking in the context of close and frequent interactions with citizens. *Professions and Professionalism*, 6 (2), 1–17. doi:10.7577/pp.1522

Hartfield, B., Shaw, J., Pinfold, V., Bindman, J., Evans, S., Huxley, P. and Thornicroft, G. (2001) Managing severe mental illness in the community using the Mental Health Act 1983: a comparison of supervised discharge and guardianship in England. *Social Psychiatry and Psychiatric Epidemiology*, 36, 508-15.

Hatfield, B. (2008) ‘Powers to detain under mental health legislation in England and the role of the Approved Social Worker: An analysis of patterns and trends under the 1983 Mental Health Act in six local authorities’, *British Journal of Social Work,* 38(8), pp. 1553-1571.

Hautomäki, L. (2018) Uncertainty work and temporality in psychiatry: How clinicians and patients experience and manage risk in practice? *Health, Risk & Society. This issue.*

Hesse-Biber, S. N. (2017) *The practice of qualitative research*. 3rd edition. California: Sage.

Heyman, B. (2010) Health risks and probabilistic reasoning. In B. Heyman, A. Alaszewski, M. Shaw, & M. Titterton (Eds.), *Risk, safety and clinical practice: Healthcare through the lens of risk* (pp. 85–106). Oxford: Oxford University Press.

Heyman, B., Alaszewski, A., and Brown, P. (2012) Health care through the ‘lens’ of risk and the categorisation of health risks – an editorial. *Health, Risk & Society*, 14(2), 107–115.

Hemmington, J. and Vicary, S. (2023) *Making Decisions in Compulsory Mental Health Work: Boundaries, Bristol, Frames and Perspectives*. Bristol University Press.

Hilton, C. (2007) Changes between the 1959 and 1983 Mental Health Acts (England & Wales), with particular reference to consent to treatment for electroconvulsive therapy. *History of Psychiatry*. 2007;18(2):217-229.

Holmes, A. G. (2020) Researcher positionality – A consideration of its influence and place in qualitative research – A new researcher guide. *Shanlax International Journal of Education*, 8(4), 1–10. https://doi.org/10.34293/education.v8i4

Hookway, C. (2010) Some varieties of epistemic injustice: Reflections on Fricker. Episteme 7 (2), 151–163.

Hoolachan J., (2019) *Rapport and Over Rapport with Research Participants*. Available at:https://methods.sagepub.com/foundations/rapport-and-over-rapport-with-research-participants (Accessed: July 2024)

Horlick-Jones, T. (2005) On ‘risk work’: Professional discourse, accountability, and everyday action. *Health, Risk & Society*, 7(3), 293–307. doi:10.1080/13698570500229820.

Houston, S. (2001) Beyond Social Constructionism: Critical Realism and Social Work. *British Journal of Social Work*. 31(6), 845-861.

Humphries, B. (2008) *Social Work Research for Social Justice.* Basingstoke: Palgrave Macmillan.

Hunter, R. A., MacAlpine I. (1974) Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973. *A medical and social history*. Dawsons of Pall Mall.

Karban, K., Sparkes, T., Benson, S., Kilyon, J., and Lawrence, J. (2020) Accounting for Social Perspectives: An Exploratory Study of Approved Mental Health Professional Practice, *The British Journal of Social Work*, Volume 51, Issue 1, January 2021, Pages 187–204, https://doi.org/10.1093/bjsw/bcaa037

Keating, F. (2016) Racialised communities, producing madness and dangerousness. Intersectionalities: *A Global Journal of Social Work Analysis, Research, Policy and Practice* 5(3): 173–185.

Keating, F. (2009), "*African and Caribbean men and mental health", Ethnicity and Inequalities in Health and Social Care*, Vol. 2 No. 2, pp. 41-53. https://doi.org/10.1108/17570980200900015.

Keating, F. and Robertson, D. (2004) *Fear, black people and mental illness: a vicious circle?* London: Blackwell Publishing Ltd.

Keating, F., Robertson, D., McCulloch, A. & Francis, E. (2002) *Breaking the Circles of Fear: A review of the relationship between mental health services and African and Caribbean communities.* London: Sainsbury Centre for Mental Health.

Kenny, K. (2008) Aesthetics and Emotion in an Organisational Ethnography. *International Journal of Work Organisation and Emotion*. 2(4), 374-388.

Keown, P., Weich, S., Bhui, K. S. and Scott, J. (2011) 'Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: Ecological study', *British Medical Journal*, 343, doi:10.1136/bmj.d3736.

Keown, P., Mercer, G., Scott, J. and Clement, S. (2018) 'The role of the AMHP in mental health services: Challenges and perspectives', *Journal of Social Work Practice*, 32(3), pp. 265–278.

Killaspy, H. (2006) From the asylum to community care: Learning from experience. *British Medical Bulletin* 79**-**80**(1):** 245 – 258. doi: 10.1093/bmb/ldl017.

Kinney, M. (2009) *Being Assessed under the Mental Health Act – Can It Ever Be Ethical? Ethics and Social Welfare* 3 (3): 329–336. doi:10.1080/17496530903209584. (He concludes the main resource in an MHA assessment is the AMHP themselves (Kinney 2009, 336).

Kjellin, L., Wallsten, T. and Lindstrom, L. (2006) 'Short-term outcome of inpatient psychiatric care: Impact of coercion and treatment characteristics', *Social Psychiatry and Psychiatric Epidemiology*, 41(12), pp. 975 – 80.

Knott, G. and Bannigan, K. (2013) A critical review of the approved mental health professional role and occupational therapy. *British Journal of Occupational Therapy,* 76(3), 118-126.

Koch, T., & Harrington, A. (1998) Reconceptualising rigour: The case for reflexivity. *Journal of Advanced Nursing*, 28, 882–890.

Lackey, J. (2020) False Confessions and Testimonial Injustice, 110 *J. CRIM. L. & CRIMINOLOGY*43. https://scholarlycommons.law.northwestern.edu/jclc/vol110/iss1/4

Langan, J. (1989) Factors approved social workers take into account when using the compulsory powers under the mental health act 1983. Department of Social Work, University of East Anglia, Norwich.

LeBlanc, S., Kinsella, E.A. (2016) Toward epistemic justice: a critically reflexive examination of ‘sanism’ and implications for knowledge generation. *Stud. Soc. Just*. 10 (1), 59–78.

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic Inquiry*. Newbury Park, Ca., Sage.

Longhofer, J. and Floersch, J. (2012) ‘An example of social work practice ethnography’, in S. Becker, A. Bryman and H. Ferguson (eds), *Understanding Research for Social Policy and Social Work*, Bristol, Policy Press, pp. 305 – 7 Lupton, D. (1999) *Risk* (London: Routledge).

Macdonald, K. I. and Macdonald, G. M. (1999) Perceptions of risk. In P. Parsloe (ed.) *Risk Assessment in Social Care and Social Work* (London: Jessica Kingsley), pp. 17 – 52.

Maidment, I., Brown, P. and Calnan, M. (2011) An exploratory study of the role of trust in medication management within mental health services, *International Journal of Clinical Pharmacy,* 33, 4: 614–20.

Manktelow, R., Hughes, P., Britton, F., Campbell, J., Hamilton, B. and Wilson, G. (2002) The Experience and Practice of Approved Social Workers in Northern Ireland, *British Journal of Social Work,* 32(4), pp. 43-61.

Marvasti, A.B. (2004) *Qualitative Research in Sociology*. London: Sage.

Medina, J. (2013) *The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and the Social Imagination*. Oxford University Press, Oxford.

Merino, Y., Adams, L., Hall, W. J. (2018) *Implicit Bias and Mental Health Professionals: Priorities and Directions for Research.*

Mind (2018) *Mind’s submission to the Mental Health Act Review*.

Mithran, S. (2024) *Mounting demand for AMHPs and unmet need masked by fall in number of detentions*. Available from://Mounting demand for AMHPs and unmet need masked by fall in number of detentions, say leads - Community Care (Accessed 12/03/2025).

Mohdin, A. (2021) *Mental Health Act reforms aim to tackle high rate of black people sectioned.* Available at: https://www.theguardian.com/world/2021/jan/13/mental-health-act-reforms-black-people-sectioned (Accessed: 30 January 2021).

Molas, A. (2016) Silent voices, hidden knowledge: ecological thinking and the role of mental health advocacy. *Dialogue* 55 (01), 87–105.

Morse, J. M. (1999) Qualitative generalisability, *Qualitative Health Research* 9(1): 5-6.

Nacro (2007) *Black communities, mental health and the criminal justice system*. London: Nacro.

Nathan, R., Bogg, D. and Lewis, H. (2021) *Emotional resilience in mental health professionals*. London: Routledge.

Nazroo, J., Halvorsrud, K., Otis, M., Hajdukova, E. B., and Bhui, K. (2019) Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Journal of Social Psychiatry and Psychiatric Epidemiology* (2019) 54:1311–1323 https://doi.org/10.1007/s00127-019-01758-y

Newbigging, K., and Ridley, J. (2018) Epistemic struggles: The role of advocacy in promoting epistemic justice and rights in mental health, *Social Science & Medicine*, Volume 219,2018,Pages 36-44, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2018.10.003.

NHS Digital (2021) *Mental Health Act Statistics,* Annual Figures - 2020-21.

NHS Digital (2018) *Mental Health Act Statistics*, Annual Figures 2017-18. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures (Accessed: 28 July 2019).

Nowell, L., Norris, J., White, D., and Moules, N. (2017) Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*.16, 1-3.

Office of National Statistics. (2012) *Ethnicity and national identity in England and Wales*. London, UK: Author.

O'Hare, P., Davidson, G., Campbell, J., and Maas-Lowit, M. (2013) Implementing Mental Health Law: A Comparison of Social Work Practice across Three Jurisdictions. *The Journal of Mental Health Training, Education and Practice* 8 (4): 196–207. doi:10.1108/JMHTEP-12-2012-0044.

O'Reilly, K. (2009) *The key Concepts in Ethnography*. London: Sage.

Parliament Post (2022) *Mental Health Act Reform - Race and Ethnic Inequalities*.

Patel, S. (2014) Racing madness: The terrorizing madness of the post-9/11 terrorist body. In L. Ben-Moshe, C. Chapman, & A. C. Carey (Eds.), *Disability incarcerated* (pp. 201–215). Basingstoke, UK: Palgrave Macmillan.

Patton, M. Q. (2015) *Qualitative Research & Evaluation Methods. Integrating Theory and Practice*. 4th Edition. London: Sage

Peay, J. (2003) *Decisions and Dilemmas: Working with Mental Health Law*. Oxford: Hart.

Pettersen, K. (2016) Understanding uncertainty: Thinking through in relation to high-risk technologies. In A. Burgess, A. Alemanno, & J. Zinn (Eds.), *Routledge handbook of risk studies* (pp. 39–48). London: Routledge.

Pilgrim, D. (2007) New mental health legislation for England and Wales: some aspects of consensus and conflict. *Journal of Social Policy* 36(1): 79-95.

Price, M. (2011) *Mad at school: Rhetorics of mental disability and academic life*. Ann Arbor, MI: University of Michigan Press.

Power, M. (2004) *The risk management of everything: Rethinking the politics of uncertainty.* London: Demos.

Power, M. (2016) Introduction – risk work: The organisational life of risk management. In M. Power (Ed.), *Risk work: Essays on the organizational life of risk management* (pp. 1–25). Oxford: Oxford University Press.

Quirk, A., Lelliott, P., Audini, B**.,** and Buston, K. (2003) “Non-Clinical and Extra-Legal Influences on Decisions about Compulsory Admission to Psychiatric Hospital.” *Journal of Mental Health* (Abingdon, England) 12 (2): 119–130. doi:10. 1080/0963823031000103434.

Quirk, A., Lelliott, P. and Seale, C. (2006) ‘Mental health act assessments in the community: A qualitative study of the experience of approved social workers’, *British Journal of Social Work*, 36(5), pp. 761–777.

Radoilska, L (2020) Revisiting Epistemic Injustice in the Context of Agency. *Ethical Theory and Moral Practice*, 23. pp. 703-706. ISSN 1386-2820. (doi:10.1007/s10677-020-10138-4)

Ridley, D. (2012) *The literature review: A step-by-step guide for students* (2nd ed.). SAGE Publications.

Rimke, H. and Brock, D. (2012) The culture of therapy: Psychocentrism in everyday life. In D. Brock, R. Raby & M. Thomas (Eds.), *Power and everyday practices* (pp. 182-202). Toronto: Nelson.

Ritchie, J. H., Dick, D., & Lingham, R. (1994) *The report of the inquiry into the care and treatment of Christopher Clunis*. Norwich, UK: HMSO.

Rogers, A. and Pilgrim, D. (2014) *Sociology of mental health and illness*. 5th edition. Maidenhead: Open University Press.

Sanati, A., Kyratsous, M. (2015) Epistemic injustice in assessment of delusions. *J. Eval. Clin. Pract*. 21 (3), 479–485.

Santori, D., and Jin, J. (2023) Globalization, Policy Mobilities, and the Method of Network Ethnography. *ECNU Review of Education*, *6*(4), 507-517. https://doi.org/10.1177/20965311231198254.

Sashidharan, S.P. (2003) *Inside Outside – improving mental health services for black and minority ethnic communities in England*. London: Department of Health.

Savin-Baden, M. (2004) Achieving Reflexivity: Moving Researchers from Analysis to Interpretation in Collaborative Inquiry. *Journal of Social Work Practice*. 18(3), 365-378.

Shah, S. R., Ahmad, F. and Khan, R. (2018) Writing a Critical Review of Literature: A Practical Guide for English Graduate Students. Global Language Review III(I):136-153. DOI: 10.31703/glr.2018(III-I).09

Shaw, I. and Gould, N. (2001) *Qualitative Research in Social Work,* London, Sage.

Schön, D. (1987) *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Profession*. San Francisco, CA: Jossey-Bass.

Cohen, A. S., Docherty, N. M., Najolia G.M., and Schwartz, E.K. (2019) Exploring the racial diagnostic bias of schizophrenia using behavioural and clinical-based measures. *J Abnorm Psychol*. 2019;128(3):263.

Scrutton, A.P. (2017) *Epistemic Injustice and Mental Illness*. Routledge Handbook of Epistemic Injustice. Routledge, New York.

Sheppard, Michael. (1990) Mental Health: The Role of the Approved Social Worker. Sheffield: *Joint Unit for Social Services Research*.

Shorter, E. (2007). Historical development of mental health services. In M. Knapp, D. McDaid, E. Mossialos & G. Thornicroft (Eds.), *Mental health policy and practice across Europe* (pp. 15-33). Open University Press.

Silbey, S.S. (2005). After Legal Consciousness. *Annual Review Law Society Sci*. (1), pp. 323-68.

Silverman, D. (2011) *Interpreting Qualitative Data: A Guide to the Principles of Qualitative Researc*h. London, Sage.

Simpson, M. (2020) *A Structured Narrative Literature Review of Approved Mental Health Professional Detention Decisions: An Infusion of Morality, Practice*, 32:4, 285-300, DOI: 10.1080/09503153.2020.1782874.

Singh SP, Burns T, Tyrer P, Islam Z, Parsons H, Crawford MJ (2013). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*. Published online: 24 June 2013. doi:10.1017/ S003329171300086X.

Singh SP, Greenwood N, White S, Churchill R. (2007) Ethnicity and the Mental Health Act 1983. *Br J Psychiatry* 2007; 191: 99–105.

Skinner, L. (2006) "*Negotiating Uncertainty: Mental Health Professionals' Experiences of the Mental Health Act Assessment Process*." DClinPsych diss., University of Leicester.

Solanki, J. (2020) *Experiences of adults from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act (1983*).

A thesis submitted for the degree of Doctorate in Clinical Psychology School of Health and Social Care University of Essex.

Spendlove, Z. (2018) Risk and boundary work in contemporary maternity care: Tensions and consequences. *Health, Risk & Society, 20(1–2). this issue.*

Stanley, T. (2018) The relevance of risk work theory to practice: The case of statutory social work and the risk of radicalisation in the UK. Health, *Risk & Society*, 20(1–2). this issue.

Stanley, T. (2013) Our tariff will rise': Risk probabilities and child protection. *Health Risk and Society*, 15(1), 67–83.

Stevens, M., Martineau, S., Manthorpe, J., Steils, N. and Norrie, C. (2018) *'Who wants to be an Approved Mental Health Professional?'* London: Social Care Workforce Research Unit, King's College London.

Stevens, J., Howarth, S. and Swindells, R. (2018) The AMHP workforce in England: Analysis of capacity, demand, and pressures. NHS Digital.

Stone, K. (2019) Approved Mental Health Professionals and Detention: An Exploration of Professional Differences and Simularities. *Practice*, 31:2, 83-96, DOI: 10.1080/09503153.2018.1445709

Stone, K. (2017) *"Decisions on Risk and Mental Health Hospital Admission by Approved Mental Health Professionals*." DSocSci diss., University of Bristol.

Szmukler, G. and Rose, N. (2013) 'Risk assessment in mental health care: Values and costs', *Behavioral Sciences & the Law*, 31(1), pp. 125–40.

Terry, G., N. Hayfield, V. Clarke, and V. Braun. 2017. "Thematic Analysis." *In The Sage Handbook of Qualitative Research in Psychology,* edited by C. Willig and Stainton-Rogers, 17–37. 2nd ed. London: Sage.

Tew, J. (2005) *Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress,* London, Jessica Kingsley.

Thomas, P. (2012) *Black and Mad: Inquiry into the 'Schizophrenia' Label.* Available at: http://www.schizophreniainquiry.org/news/black-and-mad (Accessed: 30 July 2016).

Thomas, S., McCrone, P. and Fahy, T. (2009) How do psychiatric patients in prison healthcare centres differ from inpatients in secure psychiatric inpatients units? *Psychology Crime and Law*, 15(8): 729-42.

Thornicroft, G. (1991) Social Deprivation and Rates of Treated Mental Disorder. Developing Statistical Models to Predict Psychiatric Utilisation. *British Journal of Psychiatry*, 158, pp. 475-484.

Townsend, L., Cutter, P. and Rose, D. (2020) ‘The lived experiences of Approved Mental Health Professionals (AMHPs): An interpretive phenomenological analysis’, *Health & Social Care in the Community*, 28(4), pp. 1243–1251.

Turnbull, J., Prichard, J., Pope, C., Brook, S., & Rowsell, A. (2017). Risk work in NHS 111: The everyday work of managing risk in telephone assessment using a computer decision support system. *Health, Risk & Society,* 19(3–4), 189–208.

Unsworth, C. (1987) The Politics of Mental Health Legislation, Oxford University Press.

Van Loon, J. (2014) Remediating risk as matter–Energy–Information flows of avian influenza and BSE. *Health, Risk & Society*, 16(5), 444–458. doi:10.1080/13698575.2014.936833.

Veltkamp, G., and Brown, P. (2017) The everyday risk work of Dutch child-healthcare professionals: Inferring ‘safe’ and ‘good’ parenting through trust, as mediated by a lens of gender and class. *Sociology of Health & Illness*, 39(8), 1297–1313. doi:10.1111/1467-9566.12582.

Vicary, S. (2017) *An Interpretive Phenomenological Analysis of the Impact of Professional Background on Role Fulfilment: A Study of Approved Mental Health Practice*. PhD diss., University of Manchester.

Wallcraft, J., Read, J., and Sweeney, A. (2003) On our own terms: Users and survivors of mental health services working together for support and change. *Sainsbury Centre for Mental Health.*

Warner, J. (2006) Inquiry reports as active texts and their function in relation to professional practice in mental health. *Health, Risk and Society,* 8(3): 223-37.

Warner, J. (2007) ‘Community care, risk and the shifting locus of danger and vulnerability in mental health’ in Petersen, A. and Wilkinson, I. (Eds) *Risk, Health and Vulnerability* (1st ed.). Routledge.

Warner, J. (2015) *The emotional politics of social work and child protection*. Bristol: Policy Press.

Warner, J., Heller, N.R., Sharland, E. and Stanford, S. (2017) “The historical context of the risk paradigm in mental health policy and practice: how did we get here?”, in: Stanford, S., Sharland, E., Heller, N.R. and Warner, J. (Eds), *Beyond the Risk Paradigm in Mental Health Policy and Practice*, Palgrave, London, p.1-16.

Warner, J. and Gabe, J. (2008) Risk, Mental Disorder and Social Work Practice: A Gendered Landscape. *British Journal of Social Work (2008) 38, 117–134* doi:10.1093/bjsw/bcl334.

Watson, T. (2011). Ethnography, reality, and truth: The vital need for studies of ‘how things work’ in organizations and management. *Journal of Management Studies*, 48(1), 202–217.

Webber, M. and Huxley, P. (2004) ‘Social exclusion and risk of emergency compulsory admission. A case-control study’, *Social Psychiatry and Psychiatric Epidemiology*, 39(12), pp. 1000–9.

Wedeen, L. (2010) Reflections on ethnographic work in political science. *Annual Review of Political Science,* 13, 255-272.

Wickersham, A., Nairi, S., Jones, R. and Lloyd-Evans, B. (2019) ‘The mental health act assessment process and risk factors for compulsory admission to psychiatric hospital: A mixed methods study’, *British Journal of Social Work*, 10.1093/bjsw/bcz037.

Wilkinson, J. (1998) Danger on the street: mental illness, community care and ingratitude, in: Symonds, A. and Kelly, A. (Eds) *The Social Construction of Community Care,* pp. 208-219. Basingstoke: Palgrave Macmillan.

Williams, J. and Keating, F. (2000) ‘Abuse in mental health services: Some theoretical considerations’, *Journal of Adult Protection* 2(3): 32–9.

Williams, D. and Wyatt, R. (2015) Racial Bias in Health Care and Health: Challenges and Opportunities. JAMA, 314(6), 555-556.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory, Buckingham*: Open University Press.

Wilson, K. (2021). *Mental Health law: Abolish or reform*? Oxford University Press.

World Health Organization (2018) *Mental Health, Human Rights and Standards of Care: Assessment of the Quality of Institutional Care for Adults with Psychosocial and Intellectual Disabilities in the WHO European Region*. World Health Organization, Copenhagen.

Appendices

Appendix 1: Participant Information Sheet (AMHPs)

Name of Researcher: Peter Kwaku Baffoe **E-mail:** pkb30@kent.ac.uk **Tel: 07412215812**
Title of Study: Exploring the role of Approved Mental Health Professionals in relation to the detention of people from Black and Minority Ethnic groups under the Mental Health Act (MHA) 1983

Staff Information Sheet

You are being invited to take part in a research study about the role of the approved mental health professionals (AMHP). Before you decide whether to be involved, it is important to make sure that you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully. The Researcher is Peter Baffoe, a social worker with London Borough of Merton and a PhD student at the University of Kent. The research project is funded by the National Institute for Health Research.

The purpose of the study

The study will explore and make observations about the implementation of the Mental Health Act, with particular focus on the role of the approved mental health professionals (AMHPs) in the detention process and their practice encounters with service users. I am interested in gaining insights into how decisions to detain are made by the AMHPs and the factors that influence their decision-making. You are being invited to take part in this research because I feel that your experience as a practicing AMHP can contribute to the ongoing conversation about the experiences of service users within the mental health system. This research study is being undertaking as part of my doctorate in Applied Health Research. It may also be published or presented as part of an academic paper.

Procedures:
If you agree to take part in this study, I will be observing your practice to collect information for the research and will spend an agreed number of days with you over a six-month period, observing your face-to-face encounters with service users, attending team meetings, observing your discussions with other professionals regarding referrals and assessments for detention etc. I will ask questions to clarify my understanding of what I observe. You will be asked to undertake semi structured interview with me, during which you will be asked to talk more about your work. The interview will last for approximately 1 hour. It will also involve digital recording, but please be assured that any digital recording material will be used solely for research purposes and will be destroyed upon completion of the study. Details you give will be anonymized to protect your identity and that of anyone you discuss.

Voluntary Participation:
Your decision to take part in this study is entirely up to you. It is your choice whether to participate or not. You may choose not to answer any question, as well as to withdraw completely from the study at any point during the process without having to give an explanation. Additionally, you have the right to request that your interview material should not be used.

Potential Risks to Participants:
It is possible that you may feel uncomfortable talking about your past experiences or sensitive issues, however you may choose not to answer any questions. If you are finding it difficult to discuss emotive experiences or if you become upset, I will check whether you wish to continue. You are free to answer questions in your own words, or you can stop the interview either temporarily or permanently without any consequence to you.

Benefits of being involved in the study:
Your contribution will be of great value in terms of advancing knowledge about how detention decisions are made and the factors influencing practitioners' decision-making. The study may identify the need for specific training, or policy reform. It will also contribute to the ongoing conversation around the experiences of service users within the mental health system. It is hoped that evidence generated from this study would lead to recommendations that could improve the quality of AMHP's practice, making it more beneficial to practitioners and mental health service users.

Confidentiality:
This study will be anonymized. The information that I will collect from you will be kept private. Any characteristics that could identify you will either be taken out or changed in order that your confidentiality is maintained. The only exception to the above statement on confidentiality is if there is a disclosure of any information that suggests anyone may be at immediate risk of serious harm, it will need to be reported to the appropriate authority. If this is the case, I will discuss with you how this information should be passed on to relevant parties and why.

The data will be secured using a password protected file. As I have mentioned already the digital recordings will be used solely for this research and will be destroyed on completion of the study. The transcripts of the tapes will not have any information that could be linked to you.

Ethical Approval
The project has a favourable opinion from the University of Kent Research Ethics Committee. The relevant approval reference is: 0436

Questions and Complaints:
If you have a concern about any aspect of this study, you should speak to me and I will do my best to answer your questions. If I am unable to resolve your concern or you wish to make a complaint about me or the study, please contact the Research Supervisor Dr Jo Warner (01634 888 946 / j.warner@kent.ac.uk)

Contact for Further Information

Please email or phone me on the contact details above or speak to me directly and we can arrange a convenient time to meet or I can answer any further questions. Thank you for the time you have taken to read this information sheet.

University of Kent | School of Social Policy, Sociology and Social Research

Appendix 2: Participant Information Sheet

Name of Researcher: Peter Kwaku Baffoe **E-mail:** pkb30@kent.ac.uk **Tel: 07412215812**
Title of Study: Exploring the role of Approved Mental Health Professionals in relation to the detention of people from Black and Minority Ethnic groups under the Mental Health Act (MHA) 1983

Service User Information Sheet

My name is Peter Baffoe, and I am a PhD student at the University of Kent. You are being invited to take part in a piece of research about the role of the approved mental health professionals (AMHP), and the experiences of people who have been detained under the mental health law. Before you decide whether to take part, it is important to make sure that you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the study for?

The study intends to examine how decisions are made about your care and treatment. I am interested in understanding how professionals make detention decisions and the factors they take into account. I also want to hear the views and accounts of people who have been 'sectioned' before to understand how they experienced the detention process and the care provided to them. This will hopefully identify changes with the potential to improve people's experiences of detention. I will be writing a report about the findings, which will be assessed as part of my training.

Why have I been invited to take part?

I am inviting you to take part because you have experience of services that I think may be helpful for this research

Do I have to take part?
It is entirely up to you whether or not you take part, and you should not feel pressured to be involved. If you decide to take part, you will be asked to sign a consent form, but you can change your mind at any point and withdraw without having to give a reason and without any effect on you. You also have the freedom to answer or not to answer any questions. Additionally, you have the right to request that the information you had given should not be used.

What would I be asked to do if I took part?
You will be asked to take part in an interview with me lasting up to one hour. During the interview, I will ask you questions based on your experiences of services. If you agree, I will use audiotape to record the interview so that I do not miss anything important you might say, but please be assured that any audiotape material will be used solely for research purposes and will be destroyed upon completion of the study. Following the interview, there will be some time to debrief with the researcher. After the research has been written up, you may be invited to discuss it again with me if you would like to.

Will taking part cost me anything?
No, the study will only require some of your time.

What are the possible disadvantages of taking part?
The research relates to your experience of detention. It is possible that you may feel uncomfortable talking about your past experiences or sensitive issues, however you can choose not to answer any questions. I will be mindful of this during the interview, and I have experience working with individuals who are experiencing emotional distress. You will have the opportunity at the end of the interview to discuss any concerns and you will be able to withdraw from the research at any time without having to give me a reason if you would like to.

What are the possible benefits of taking part in the study?
Taking part in this research will help us understand what it is like to use mental health services. Talking about your experience and circumstances is likely to contribute to knowledge and understanding of how to resolve longstanding concerns associated with detention and the negative experiences of individuals with mental health conditions. The study will hopefully identify changes with the potential to improve quality of care and treatment offered to people with mental health needs. You will also be given £10 voucher for your time.

Will what I say in this study be kept confidential?

The information that I will collect from you will remain private and no one will be named in the final report or any other reports that I write as a result of doing this research. Your name and any other information that could identify you will either be removed or changed in order that you cannot be identified by anyone. The data will be secured using a password protected file. As I have mentioned already the audio-tape recordings will be used solely for this research and will be destroyed on completion of the study.

Ethical Approval

The project has been given ethical approval by the University of Kent Research Ethics Committee (Ref: 0436).

Questions and Complaints:

If you have a concern about any aspect of this study, you should speak to me and I will do my best to answer your questions. If I am unable to resolve your concern or you wish to make a complaint about me or the study, please contact the Research Supervisor Dr Jo Warner (01634 888 946 / j.warner@kent.ac.uk)

Contact for Further Information

Please email or phone me on the contact details above or speak to me directly and we can arrange a convenient time to meet or I can answer any further questions. Thank you for the time you have taken to read this information sheet.

University of Kent

Appendix 3: Consent Form (AMHPs)

Title of study: Exploring the role of Approved Mental Health Professionals in relation to the detention of people from Black and Minority Ethnic groups under the Mental Health Act (MHA) 1983
Name of Researcher: Peter Kwaku Baffoe
Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understood the information sheet dated (.............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reasons. ☐

3. I understand that the researcher may be present to observe, without undue interference and judgement, all aspects of my work unless for service user reasons it was deemed to be inappropriate. ☐

4. I understand that the researcher may wish to observe and record team meetings in which I am participating. ☐

5. I agree for the interview to be audio recorded. I understand that any digital recording material will be used solely for research purposes and will be destroyed on completion of your research. ☐

6. The procedures regarding confidentiality have been clearly explained. I understand that my responses will be anonymised before analysis. ☐

☐

7. I understand that the researcher will present the analysed data in his PhD thesis and some other future reports and publications, but my anonymity will be safeguarded in any use of this information.

8. I agree to participate in the above research project. ☐

Name of participant	Date	Signature
Name of person taking consent *(if different from researcher)*	Date	Signature
Name of researcher	Date	Signature

University of Kent

Appendix 4: Consent Form (service users)

Title of study: Exploring the role of Approved Mental Health Professionals in relation to the detention of people from Black and Minority Ethnic groups under the Mental Health Act (MHA) 1983
Name of Researcher: Peter Kwaku Baffoe
Participant Identification Number for this project:

Please initial box

9. I confirm that I have read and understood the information sheet dated (...............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

10. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reasons, without my medical care or legal rights being affected. ☐

11. I agree for the interview to be audio recorded. I understand that any digital recording material will be used solely for research purposes and will be destroyed on completion of your research. ☐

12. The procedures regarding confidentiality have been clearly explained. I understand that my responses will be anonymised before analysis. ☐

13. I understand that the researcher will use direct quotations from this interview, will present the analysed data in his PhD thesis and some other future reports and publications, but I will not be identified in any of the reports that results from the research. ☐

☐

14. I understand that I will have the opportunity to request for a summary of the final report, and to meet with the researcher to discuss findings should I choose to.

15. I agree to take part in the above study as outlined to me. ☐

Name of participant	Date	Signature
Name of person taking consent *(if different from researcher)*	Date	Signature
Name of researcher	Date	Signature

Appendix 5: Interview guide - AMHP

Introductory Comments – including duration of the interview, demographic information, Job role and professional qualification, length of time and experience as an AMHP and in social care more generally.

General questions:

- *Can you tell me when you became an AMHP and what drew you to this work?*
- *What is it you enjoy most about this work?*
- *What do you find most challenging?*
- *Can you tell me about the level of support you receive in discharging your role?*
- *Are there any challenges in terms of your independence as an AMHP?*
- *What do you think hinders / facilitate good AMHP practice?*

Topics

MHA assessment – risk, medical and social factors:

- *Please tell me about a Mental Health Act assessment you recently completed.*
- *Can you describe the relevant factors and circumstances that led to your decision to detain or to not detain?*
- *What do you think the service user's understanding of their situation / condition was?*

Experience of working with service users from BME communities:

- *Can you tell me about your experience of working with service users from BME communities?*
- *What do you think are the needs and concerns of these service users?*
- *Have you received any complain from these service users about the services they receive?*

AMHPs views on service user experience, voice, preferences and level of participation in decision making:

- *Explore the AMHPs perceptions of the service users' knowledge, circumstances and experience - what do you think the service user felt about their situation at that point? why do you think they felt the way they did?*
- *In what ways did you consult with the service user and their carers / family members in decision regarding the compulsory admission?*
- *What do you think are the challenges (if any) in terms of consulting or involving service users in decision making?*

- *Did you consider any alternatives or community services?*

The above pre-planned topics / questions will be followed by spontaneous questions, prompts and probes in response to a participant’s answers or body language.

At the end of each interview, I will restate the key points made by participants, and record their first impressions and the highlights of the interview in a debriefing session.

Appendix 6: Interview guide – service users

Introductory Comments – featuring duration of the interview, demographic information, and review of participant information sheet and consent form.

Topics

Experience of detention

- *Can you talk about your experience of being detained?*
- *Can you describe the circumstances that led to your detention?*
- *How appropriate do you think hospital admission was for you at that time?*
- *From your experience, is there anything that you feel has been particularly helpful / unhelpful?*

Experience of working with AMHPs and other professionals

- *Can you talk about your experience of receiving care and treatment from mental health professionals including the AMHPs*
- *Can you describe your relationship with the professionals involved in your care?*
- *Please tell me about what you liked / dislike about working with the AMHP?*

Voice of service users in formulating knowledge about issues that matter to them

- *Did you feel listened to by the professionals involved in your care?*
- *In what ways did the worker involve you in decision making about your care?*
- *Can you tell me whether you wanted to take part in decision making about your treatment? If yes, did you feel any sense of participation?*

Views on access to other services including independent mental health advocacy (IMHA)

- *Can you describe your experience of community services?*
- *Did you ever have to use an independent mental health advocate during the detention process?*
- *If yes:*
  - *i. What difference did it make in terms of getting your voice heard?*
  - *ii. How did you feel about accessing the help of IMHA during meetings with AMHPs and other professionals?*

Is there anything else that you would like to share or add about your experience of detention?

The above pre-planned topics / questions will be followed by spontaneous questions, prompts and probes in response to a participant's answers or body language.

At the end of each interview, I will restate the key points made by participants, and record their first impressions and the highlights of the interview in a debriefing session

Appendix 7: Topic guide for observation

- Where is the social life taking place / unfolding? What is going on?
- What interactions are taking place? Between whom?
- Who is present at the meeting? Who is missing?
- What is the key topic of discussion?
- What are the points of conflict / agreement?
- How does power relation play out in practice?
    1. *Whose voice is dominant?*
    2. *Pay attention to body language, silences, and contradictions; listen out for things that might sound like justification for specific actions / decisions, how the AMHP might explain their decisions to the service user, and how they might negotiate with them, giving them choices etc.*
    3. *In what ways do AMHPs exercise their independence or discretion over a decision to detain or not? What level of influence do the doctors and team managers / supervisors have on AMHP decisions?*
- What risk factors do practitioners consider when making decisions? How do they think about and construct risks as they arrive at a decision?
- What social circumstances do they consider?
- How do practitioners and service users (respectively) see or interpret a behaviour or an incident?
- Are the decisions patient-centred – is the patient actively involved in decision making about their care and treatment?
- Do service users understand the detention process, their rights and complain procedures?
- Do practitioners take into account the knowledge and experience of service users in forming a judgement?
- Where is the patient's 'voice' in the detention decisions?

Appendix 8: Recruitment Flyer

INVITATION TO TAKE PART IN MENTAL HEALTH RESEARCH!

My name is **Peter Baffoe**, and I am a PhD student at the University of Kent. I am looking for people to take part in a study about the **mental health needs of people from black and minority ethnic communities** with lived

What is involved in this research?

As part of the research, you will take part in an **interview** with me asking you to talk about your **experiences of being detained**. The interview will last up to one hour. The information you give will be kept private and confidential.

You will be **given £10 voucher** at the end of the interview for your time

To take part, you must be an **adult with lived experience of detention** and identify as being from **black and minority ethnic background.** You must speak English and have the capacity to give written agreement to take part.

If you are interested and would like to know more about the research, please contact :

Peter Baffoe 07412215812 / pkb@kent.ac.uk

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Appendix 9: Ethical Approval

Student Research Ethics Committee

Reviewer Comments 0436/1

Applicant Name: Peter Kwaku Baffoe

Title of Project: Exploring the Approved Mental Health Professionals in relation to the definition of people form Black and Minority Ethnic groups under the Mental Health Act (MHA) 1983.

Reviewers Name:

Please clearly mark "X" in your decision for the outcome of this ethics application:

Proceed: ☒

Proceed with amendments: ☐

(This will not need to be re-approved by reviewers)

Reject and resubmit: ☐

(This will need to be seen and approved by reviewer after re-submission)

Comments regarding the application form:

This looks good overall. It is surprising that there is not more research on how mental health professionals make decisions about 'sectioning' BME people. This is clearly going to be an important piece of research. The ethics application itself

has no comments from the supervisor – but it is signed, so I assume that she has given her approval.

Comments regarding the Research Instrument:

The interview guide is clear and the questions appropriate. Nice recruitment flyer. A topic guide is rather unusual, but this seems ok.

In terms of your sample, if you are aiming for 20 service users (and 20 MH assessors), there is bound to be a diverse range of attributes – age, gender, ethnicity. More information about how to manage that diversity would be good. Do you mean to focus specifically on Black people who have experienced this procedure/practice?

Comments regarding the consent Form:

The consent forms if fine.

Comments regarding the Information Sheet:

This is very clear. There is one full-stop missing in one of the sentences, but it is otherwise very good.

LSSJEthics@kent.ac.uk

Appendix 10: Participants and Codes

To ensure confidentiality all the participants involved in the study were assigned pseudonym.

Participants and Codes - Research site 1

AMHPs

Participant 1 - Mary

Participant 2 - George

Participant 3 - Yasmin

Participant 4 - Kevin

Participant 5 - Vivian

Participant 6 - Anna

Participant 7 - Venus

Participant 8 – Eve

Service users

Participant 1 - Ken

Participant 2 - Amin

Participant 3 - Martin

Participant 4 - Rita

Participant 5 - Sean

Participant 6 - Tom

Participant 7 - Wesley

Participants and Codes - Research site 1

AMHPs

Participant 1 - Bridget

Participant 2 - Denise

Participant 3 - Amber

Participant 4 - Jane

Participant 5 - Pamela

Participant 6 - Jason

Service users

Participant 1 - Finn

Site1 – Main research site

Site 2 – Secondary research site

Wk – Week of study (observation)