**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?**

¹\*Michael Bonnet, ¹Dr Nicola Moran  
  
¹ International Centre for Mental Health Social Research, Dept. of Social Policy and Social Work, University of York, York, YO10 5DD, UK.

\*Correspondence to be sent to: Michael Bonnet, [m.bonnet85@gmail.com](mailto:m.bonnet85@gmail.com)

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**Abstract**

The number of people detained in England under the Mental Health Act 1983 has risen significantly in recent years and has recently been the subject of an Independent Review. Most existing research into the rise in detentions has tended to prioritise the perspectives of psychiatrists and failed to consider the views of Approved Mental Health Professionals (AMHPs), usually social workers, who ultimately determine whether detention is appropriate. This mixed-methods study focused on AMHPs’ views on the reasons behind the rise in detentions and potential solutions. It included a national online survey of AMHPs (n=160) and semi-structured interviews with six AMHPs within a Community Mental Health Team in England. AMHPs reported that demand for mental health services vastly exceeded supply and, due to inadequate resources, more people were being detained in hospital. AMHPs argued that greater investment in preventative mental health services and ‘low intensity’ support would help to mitigate the impact of social risk factors on mental health; and greater investment in crisis services, including non-medical alternatives to hospital, was required. Such investment at either end of the spectrum was expected to be more effective than changes to the law and lead to better outcomes for mental health service users.

**Keywords**

AMHPs, detentions, MHA, Independent Review, England.

**Introduction**

The number of compulsory admissions, the process by which someone is detained in hospital under the Mental Health Act (MHA) (1983) due to the risk their mental state is perceived to pose to themselves or others, is rising. Between 2014 and 2016, detentions increased by close to 20 percent (CQC, 2018). Official figures show that not only are more detentions taking place than ever before, but that the rate of this increase has also risen rapidly in recent years (NHS Digital, 2016). In response, the UK Government commissioned an Independent Review of the MHA in 2017 to, among other things, ‘understand the causes’ of this phenomenon and to recommend changes to legislation and practice as a result (Wessely *et al*., 2018a).

Most people admitted to hospital under the Mental Health Act are detained under either Section 2 of the Act, “admission for assessment”, or Section 3 “admission for treatment”. Each of these sections carries different powers. Both stipulate that those detained must be suffering from “a mental disorder” of a nature or degree which requires the patient to be in hospital for either the patient’s own health and safety or in the interest of public protection. In the case of Section 2, an application is made for the assessment of the patient with the possibility of subsequent treatment. If the application is successful the patient can be detained for up to 28 days. With Section 3, applications are made on the grounds that it is appropriate for the patient to receive medical treatment in hospital, suitable treatment is available and such treatment cannot be provided unless the patient is detained in hospital. If the application is successful the patient can be detained for up to 6 months.

The Care Quality Commission (CQC), the independent regulator of health and social care services in England, point out that a rise in detentions isn’t necessarily ‘bad’ and could indicate that more people are getting the support they require in times of crisis and benefitting from the legal protection the MHA affords (CQC, 2018). However, extensive evidence exists documenting the ‘negative inpatient experiences’ of those who have been detained (Glasby and Tew, 2015: 97). The National Institute for Clinical Excellence for example, state that ‘being detained is, at least for some, traumatic, with a loss of dignity and respect and a feeling of not being cared for’ (NICE, 2011: 139). Moreover, in the Code of Practice for the Act itself, the principle of 'least restriction' explicitly states “Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained” (Department of Health, 2015, 1.2).

Detention then is clearly intended to be the treatment option of last resort, so why is it being used more frequently than previously? In their investigation into the causes behind the rise, the CQC cited eight possible hypotheses, including data discrepancies, an increase in so-called 'revolving door' patients, a deficit of community services able to prevent admission, wider interpretations of mental disorder amongst clinicians, the effect of a reduction of inpatient beds, and an increase in social factors which can contribute to mental ill health (CQC, 2018).

Whilst deinstitutionalisation and the shift from inpatient care to care in the community (Glasby and Tew, 2015; Ewbank *et al*., 2017) was seen optimistically as a means of facilitating greater social integration and participation among ‘one of the most marginalised groups in society’ (Cummins, 2013: 93; Pillay, 2017), the cost of delivering care in the community of a standard that enabled people to achieve the goal of more independent living was more expensive than anticipated (Knapp *et al.*, 2011). Subsequently, it has been argued that poor outcomes for patients in the community have led to an era of ‘re-institutionalisation’, whereby services are becoming increasingly reliant on ‘reproductions of the asylum’, in the form of 24-hour staffed supported housing, rehabilitation units and psychiatric beds obtained through use of the MHA, often for short periods at a time (Priebe *et al.*, 2004).

Though seemingly counterintuitive, there is evidence of a causal link between the reduction of psychiatric beds and an increase in the number of MHA detentions (Keown *et al.*, 2011). Accordingly, a far higher proportion of people in psychiatric wards are compulsorily detained (rather than admitted voluntarily) under the MHA than previously (CQC, 2018), potentially caused by ‘a 'concentrating' effect whereby the threshold for admission has increased’ (Glasby and Tew, 2015: 107).

A significant disparity exists in increases in funding for mental health services compared to other areas of the NHS (Gilburt, 2018). It has been estimated that although mental health accounts for 23 percent of total NHS activity, the budget it receives is equivalent to just half of this (Mental Health Taskforce, 2016). Meanwhile demand for mental health services has increased significantly (Gilburt, 2015). NHS Providers, the membership organisation representing NHS Trusts, has stated that ‘rapidly rising demand is overwhelming...core services; extra funding is not reaching the NHS trust frontline’ (NHS Providers, 2017).  As Quirk *et al* make clear: ‘a patient's chance of being sectioned is likely to increase when there are no realistic alternatives to in-patient care’ (2003: 119). The converse is also true and it has been proposed that the steady reduction in detentions between 2000–2009 may be ‘due to the introduction of specialist community mental health teams following publication of the National Service Framework for Mental Health in 1999’ (CQC, 2018: 5). This would suggest that far from being inevitable, rising detention rates can be ameliorated, but only under certain conditions.

The role of AMHPs

Approved Mental Health Professionals (AMHPs), 95 percent of whom are estimated to be social workers (Carson, 2018), are the professional group with overall responsibility for coordinating and conducting a MHA assessment (Morriss, 2016) and thus ultimately determining whether someone requires compulsory admission to hospital. Indeed, the allocation of this task to AMHPs is a deliberate attempt to ‘counteract the more restrictive view of the dominant medical model’ (Hall, 2017: 447); AMHPs “must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act” (Department of Health, 2015, 14.52). This decision making process however, is not unilateral. AMHPs work collaboratively with two Section 12 approved doctors during the assessment and all parties are required to agree in order for a detention to take place.

It is clear that in seeking to understand why detentions are rising and what might be done in response, AMHPs, in comparison to doctors, are an under-consulted resource. Most research on compulsory admissions under the MHA is psychiatric in both origin and focus (Campbell, 2009; Keown *et al*., 2011; Fistein *et al*., 2016; Singh *et al*., 2017). Within existing research there is minimal analysis on the role played by AMHPs as part of this process of detention. For example, Buckland’s (2014) analysis of AMHPs’ use of compulsory powers, whilst clearly stating that ‘alternatives to compulsory admission to hospital are urgently needed’ (p60), focused on the theoretical and ethical dilemmas concerning the role of the AMHP. Hall (2017) meanwhile focused on the alternatives to compulsory powers available for AMHPs to consider when conducting Mental Health Act Assessments; highlighted the challenge AMHPs face in distinguishing social problems from medical ones and stressed the relative dominance the medical narrative currently holds in this dynamic, which in turn increases the likelihood of ‘negative risk-taking’.  Hall’s study focused predominantly on the system *as-is –*effectively highlighting its strengths and weaknesses – unlike the current study which sought to explore AMHPs’ views on what provisions would need to be in place to fully realise the principle of least restriction enshrined in the Act and to safely reduce hospital admissions.

Previous research has not sought the views of AMHPs into the rise in detentions. Given the unique and fundamental role played by AMHPs in conducting MHA assessments, this underrepresentation is both surprising and short-sighted. It is also perhaps reflective of the perceived marginalisation AMHPs have felt within mental health services (Cooper and Lousada, 2005; Taylor, Lawton‐Smith and Bullmore, 2013).  This research explored the views of AMHPs on why they think detentions are increasing, and what they believe would help to counter this rise.

**Methods**

Study design

This mixed-methods study incorporated qualitative interviews with a small sample of AMHPs (n=6) and an online survey of AMHPs across England (n=160). This design aimed to marry an in-depth exploration of views around the rise in detentions with a broader snapshot of opinion amongst AMHPs (Cresswell and Plano Clark, 2011). The research was conducted prior to publication of the findings of the Independent Review.

The first stage of the study consisted of six semi-structured qualitative interviews with AMHPs working in the Community Mental Health Team in an NHS Trust in England where the first author worked as a care coordinator whilst undertaking a Master’s degree. Participation in the research was voluntary; during the recruitment process AMHPs were informed that participation would be kept confidential, their data would be anonymised, and nobody in the Trust would be made aware of who had taken part or what any individual had said. It was emphasised that the research was undertaken for the purposes of a Master’s research project and not on behalf of the Trust; all correspondence was with the first author using their University email address. The circumstances in which confidentiality may be broken, for example if there was a disclosure of harm, were clearly set out in the information sheet. During these interviews AMHPs were asked about their experiences of implementing the MHA in practice with a specific focus given to the rise in detentions. AMHPs were also encouraged to share any opinions or ideas that they had in relation to changes in policy or practice which they felt may help to reduce the numbers of people being detained, alongside their thoughts on whether reform of the MHA was the appropriate vehicle for reducing detentions.

Stage two consisted of an electronic survey distributed to AMHPs working in England. The survey was designed using Qualtrics software and asked a series of scaling questions. The purpose of the survey was to broaden the focus of the study from a local to a national setting. Respondents were asked about recurrent themes that arose in the face-to-face interviews in order to determine the extent to which AMHPs outside of the research site corroborated or contradicted local findings.

This research was granted approval from the NHS Health Research Authority (239441) and ethical approval from the University of York Social Policy and Social Work Departmental Ethics Committee (SPSW/MTA/2017/4).

Recruitment and procedure

The study used purposive sampling (Padgett, 2008), with all participants being qualified and practicing AMHPs. AMHPs working in the local service were sent an email, with the study information sheet attached, explaining the purpose of the study and requesting those interested to contact the researcher directly on their University email address. Those who volunteered were contacted to discuss the study, raise any questions about the research, and arrange a time and date for interview if they remained happy to take part. Interviews lasting up to one hour were conducted in a private room at the NHS research site in Spring 2018. A topic guide for the semi-structured interviews had been informed by the literature review. Each interview was audio-recorded, with permission, using an encrypted digital device and transcribed verbatim by the researcher.

Data gathered and analysed from these interviews helped to inform an online survey comprising a series of 17 scaling questions using the five-point Likert scale. The survey was piloted with an AMHP who did not participate in the study; feedback from the pilot was used to refine questions with the intention of making them more intuitive for respondents.

Survey recruitment took place over a five-week period in early summer 2018. The recruitment email containing a link to the anonymous online survey and an attached survey-specific information sheet was distributed, at the request of the researcher, by the National AMHP Leads Network, a group of operational and training leads for AMHPs across 153 Local Social Service Authorities, to the respective AMHP leads. The AMHP leads were asked to circulate the email to the AMHPs in their network. No upper limit was placed on potential respondents to the online survey and in total 160 were completed within the permitted time frame and analysed for this study. It was not possible to ascertain precisely how many AMHPs received the survey link and thus calculate the response rate.

Confidentiality and consent

Informed consent was obtained from all interviewees via a signed consent form completed prior to commencement of the interview, following discussion of the study and information sheet. Interview data was anonymised at the point of transcription, with interviewees only identified by ID numbers. For survey respondents consent was assumed, given the voluntary completion and submission of the survey itself. No identifying information was either requested or obtained from survey respondents. All data was stored securely on an encrypted University server.

Analysis

Qualitative data obtained through face-to-face interviews was analysed thematically using Framework Analysis (Ritchie and Spencer, 1994). This approach was chosen as it is well ‘adapted to research that has specific questions, a limited time frame, a pre-designed sample (e.g. professional participants) and *a priori* issues (e.g. organisational and integration issues) that need to be dealt with’ (Srivastava and Thomson, 2009: 73). Though theories may arise out of data analysed using this approach, the primary objective was to describe and understand what is happening in a particular setting (Ritchie and Spencer, 1994) – in this case rising detentions under the MHA. Interview transcripts were coded using *a priori* and emergent codes; a sample of the transcripts were coded by the second author, discrepancies discussed and the coding frame refined. There was a high degree of congruence between the coding of each researcher. Coded data was then summarised and charted in Word, with themes identified and systematically analysed.

Quantitative survey data was compiled into simple, descriptive statistics, which were in turn compared and contrasted with the recurrent themes emerging from face-to-face interviews.

Characteristics of respondents

In total, six AMHPs took part in interviews, and 160 AMHPs completed the online survey; Table 1, below, shows the respective length of time since qualification of AMHPs in the study.

Table 1: Number of research participants taking part in the interviews and survey by length of time since qualification as an AMHP

|  |  |  |
| --- | --- | --- |
| Number of years since qualification as an AMHP | Interviewed AMHPs | Surveyed AMHPs\* |
| 0-2 years | 1 | 32 (21 percent of those surveyed) |
| 3-5 years | 2 | 22 (14 percent) |
| 6-10 years | 2 | 26 (17 percent) |
| 11+ years | 1 | 76 (49 percent) |

\*n=156 for this specific question.

**Results**

A considerable majority of AMHPs who took part in the study felt that the trend of rising detentions was a worrying phenomenon: 76 percent (n=112/148) of AMHPs who responded to this survey question recognised the trend of rising detentions under the MHA from their own practice, and 75 percent (n=115/153) believed this to be a cause for concern. Of surveyed AMHPs, 71 percent (n=106/149) believed that the Government was right to seek to reduce the number of detentions made under the MHA. All six AMHPs interviewed also agreed, pointing out that an increase in the use of compulsory powers should be a cause for concern for professionals.

Greater number of social stressors

There was widespread belief among AMHPs that social problems and challenges were negatively impacting people’s mental health to a greater extent than had previously been the case. 69 percent (n=102/148) of survey respondents “strongly agreed” with the assertion that wider social issues had led to an increase in mental health problems among the general population. Within interviews AMHPs expressed their concern that many people were subject to increased social stressors such as experience of trauma, difficulty accessing benefits, problems associated with housing, addiction and social isolation, and were thus more reliant on services at precisely the time they seemed less able to meet people's needs. One interviewee described the local AMHP service as the "*last stop*" (Interviewee 1) for people unable to cope in this climate. Another AMHP questioned whether people experiencing difficulties as a result of pressures related to housing, immigration or the benefits system actually "*belong*" (Interviewee 2) in mental health services, raising concerns that socio-economic disadvantage is being pathologised in a way which was neither appropriate nor effective. AMHPs that subscribed to this view felt that the solution to increased demand on services lay, at least in part, outside of mental health services in wider social policy.

Overreliance on hospitalisation

There was agreement among AMHPs in both elements of the study that there is an overreliance on hospitalisation as a place of safety for people experiencing mental health crises. Ninety percent (n=132/146) of surveyed AMHPs felt that there were not enough viable alternatives to hospital admission for them to consider during MHA assessments. This point was echoed equally strongly among AMHPs interviewed in the local service. They felt that there was a lack of “*intermediary measures between the community and hospital*” (Interviewee 2) and that the level of risk crisis teams were able to manage in the community was relatively low. This was attributed to insufficient resources which prevented crisis services from more assertive and frequent follow-up of patients. In addition, AMHPs felt that at the point at which patients could no longer be managed in the community, the only realistic option for them to consider was hospital admission (either via the MHA or 'informally'), irrespective of whether hospital was the most appropriate setting to address the crisis.  A majority of interviewed AMHPs commented that a lack of a "*third place*" (Interviewee 6) sitting between hospital and the community - such as a well-resourced crisis house - meant that hospital was often used as a 'last resort' for those posing a risk to themselves. In these circumstances it was felt that though successful in preventing further harm coming to the patient, hospital did not address the underlying cause of the crisis; but in lieu of alternatives, inpatient teams were tasked with responding regardless and consequently pressures on inpatient teams increased.

Reduction in efficacy of hospital admission

In addition to the system being over-reliant on hospitalisation, AMHPs also felt that the effectiveness of a hospital admission to support those in mental health crisis could be insufficient and had diminished over time. 79 percent (n=116/147) of AMHPs who responded to this survey question thought that those admitted to hospital under the MHA were *not* given adequate time for treatment in hospital before being discharged, while 65 percent (n=95/147) observed that over the course of their careers a hospital admission had become less helpful to those in crisis than it once was. Among AMHPs in the local service a perceived paradox emerged in which admission to a psychiatric ward had become harder to obtain, whilst discharge was happening much more quickly than in the past:

"*It's a vicious cycle with rates of detention increasing, but then a shorter admission*. *People are being discharged when they're not even fully well”* (Interviewee 1).

This comment was indicative of a belief among many AMHPs interviewed that due to bed pressures, inpatient teams were discharging patients prematurely, whilst their mental state was still unstable, and consequently many of these patients required readmission using the MHA just a short period after discharge –thus contributing to an overall increase in recorded rates of compulsory admission. Interviewed AMHPs also felt that the demands on their service was exacerbated by pressures in community teams which meant follow-up of patients post-discharge was not as effective as it otherwise could be. One AMHP suggested that a disproportionate amount of scrutiny was being placed on the number of people being detained and not enough on what happened to these people after their MHA Assessment:

"*They can't refuse me a bed if I say I need one... Whereas once they're in there they've got pressure of discharging, because they've probably got targets...I think the threshold for keeping them in has lowered, rather than my threshold [for detaining them]"* (Interviewee 5).

This quote is also representative of AMHPs’ rejection of the notion that system pressures have led them to change their threshold for detaining patients, or indeed to practice under the assumption that detention is now a prerequisite to obtaining a psychiatric bed:

“*The law remains the same. We only detain if the person needs it*” (Interviewee 3).

However, although AMHPs felt their own practice had remained consistent in the face of growing demand, they did acknowledge, tacitly, that this might not be the case for all of their colleagues.

Attitudes towards potential reform of the MHA

Views on whether reforming the MHA would be an effective or desirable way to reduce detentions were mixed. Surveyed AMHPs were largely undecided on this question: 30 percent (n=45/149) of respondents, the highest number in any single category, stated they neither agreed nor disagreed with the notion that reforming the MHA would be an effective way of reducing detentions, 29 percent (n=43/149) either strongly or somewhat agreed (combined) and 41 percent (n=51/149) either strongly or somewhat disagreed. 27 percent meanwhile (n=40/148) neither agreed nor disagreed with the notion that reforming the MHA was desirable, whilst 34 percent (n=50/148) strongly or somewhat agreed and 39 percent (n=58/148) strongly or somewhat disagreed with this premise. Among AMHPs in the local service however, there was a clear consensus against reforming legislation with most AMHPs arguing that the MHA worked well and was not in need of change. Rather than reform of the Act most of these AMHPs stated they would rather see more resources allocated to mental health services and more efficient working between the different agencies involved in delivering these services. AMHPs of this view acknowledged that minor improvements could be made to the Act (such as modernisation of the Nearest Relative rule that determines which of a patient’s relatives holds certain rights under the MHA), but they did not envisage that these changes would have a substantial effect on detention rates.

A small number of interviewees were suspicious of the Government's motivations for reform of the MHA. These AMHPs feared that focusing on the MHA as a cause of rising detention rates, rather than mental health service provision more broadly, could be used as a cynical justification for not increasing spending on mental health and even as a means of removing clinical judgement as the primary means in determining whether detention is required from the legislation entirely. There were also fears among interviewed AMHPs that reform of the MHA could raise the bar for admissions still further - meaning that some patients who now meet the detention threshold, would not in future. Generally, interviewees felt the MHA worked reasonably well, but that services were not properly resourced and that inter-agency working – particularly between mental health services and the police – was poor and inefficient.

Though opposed to reform, interviewed AMHPs felt that if legislative changes were to happen they would have to be radical to have the required impact. One interviewee was in favour of such reform. Their argument was that currently the MHA is too prescriptive and creates too much bureaucracy and in order to address these issues and alter the way services work in practice, change would have to be mandated:

"*I think where we're at, to reduce detentions, you have to change the legislation*" (Interviewee 6).

Despite differing opinions on the wisdom of reform, a significant majority of AMHPs involved in this study - 92 percent (n=135/147) of survey respondents and 5 out of 6 interviewed AMHPs - agreed that greater investment in community and preventative mental health services would be *as effective* in reducing detentions as reforming the MHA. This opinion is likely informed by the belief held by 94 percent of survey respondents (n=139/148) that the provision of mental health services has not kept pace with an increase in demand. In interviews AMHPs lamented a lack of resources at both ends of the spectrum, citing reductions in 'upstream' preventative services such as day centres and support workers, alongside inadequate provision at the acute-end – such as better-resourced crisis services and more non-medical ‘places of safety’. The implication from the AMHP perspective was clear: cuts to the former have directly contributed to increased demand on the latter and, as a result, acute-services, including AMHP teams, are struggling to cope. Interviewees recalled many instances where referrals for MHA assessments, though wholly appropriate at the time they were made, may have been avoidable had there been earlier intervention. They felt that these experiences and the rise in people being detained under the MHA more generally "*poses lots of questions about whether we have the balance of services right*" (Interviewee 4).

**Discussion**

The majority of AMHPs in this study recognised the trend of increasing detentions under the MHA from their own practice; were worried about this development; and thought that the Government was right to try to do something about it. AMHPs were predominantly unsure whether changes to the MHA would be effective in reducing detentions and whether a reformed MHA that sought to reduce detentions would be an improvement on the existing Act. There was professional agreement on the problems that the AMHP service face – a rise in detentions being just one of many challenges affecting AMHPs – but there was less consensus on the best way to address these problems. This is to be expected. There is no silver-bullet solution that can solve all the problems of mental health services and we should be wary of suggestions to the contrary. The interim report on the Independent Review into the MHA, published after this study was concluded, made clear that ‘the MHA cannot be viewed in isolation from the practical and legislative context in which it operates’ and therefore improvements to services were ‘not going to be achieved by legislative means alone’ (Wessley *et al*., 2018a: 7-8).

Many of the issues highlighted by AMHPs as contributing to high detention rates echoed the CQC’s own (2018) hypotheses: greater demand for services; inadequate provision of resources; an increase in social stressors and mental ill-health ‘risk factors’; and a lack of viable community alternatives to hospital admission. But, whilst AMHPs directly connected many of these phenomena to increased use of the MHA, they also identified some of these trends as problems in their own right and suggested that these are perhaps receiving less attention than they should because the focus of public and political attention seems to be on rising detention rates and little else. For example, AMHPs pointed out what they felt was a contradiction: high levels of scrutiny placed on how many people are detained before going into hospital, but less attention on what happened to them once they were admitted.

This research also touched on another possible contributing factor to rising detention rates not considered by the CQC: the efficacy of hospital admission for people experiencing mental health crises. Four out of five survey respondents felt that people detained on psychiatric wards were not given sufficient time to recover during their admission before being discharged. AMHPs also expressed doubts about the suitability and effectiveness of hospitalisation for patients in certain situations. This observation is worrying, as it suggests that a system which is largely predicated on admitting the most unwell to hospital for treatment may not be operating as intended. If this were the case, we may expect to see significant numbers of people being re-admitted to hospital shortly after discharge, many under the MHA.  However it should be noted that the initial findings of the Independent Review did not support this view, noting instead that ‘the rise reflects more individuals being detained overall, rather than some people being detained more often’ (Wessely *et al*., 2018a: 12).

AMHPs’ depiction of an increase in the numbers of challenges faced by their profession supports the view put forward by NHS Providers (2017), that ‘rapidly rising demand is overwhelming…core services’. AMHPs in this study identified many significant and negative changes to frontline services in recent years, including: an increase in the threshold for Community Mental Health Teams to offer patients support; an increase in premature discharge of patients from psychiatric wards, sometimes before the crisis that precipitated their admission had fully abated; and a reduction in the amount of preventative work taking place that can delay or divert people from reaching the point of mental health crisis.

Together, these changes are seen by AMHPs to have led to the current situation in which there is felt to be an overreliance on the MHA. They are also indicative of a ‘concentrating effect’, similar to that described by Glasby and Tew (2015), but one which isn’t confined to an increase in the criteria necessary for admission to hospital and rather refers to a raised threshold for intervention across all aspects of the mental health system.

Final report from the Independent Review

The final report from the Independent Review of the Mental Health Act suggested a number of ideas to prevent inappropriate or prolonged detentions (Wessely *et al.*, 2018b). Recommendations included: expanding opportunities for tribunals; increasing the provision of independent advocacy; replacing the Nearest Relative rule; raising the threshold for compulsory admission and reviewing rules around the permitted length of detention under the Act.

However despite ‘rising detention rates’ being mentioned first and explicitly in the review’s terms of reference as something the Government noted ‘with concern’, the most significant changes proposed in the final report were instead focused on enhancing and protecting patient rights. Whilst this is both laudable and important, comparatively it does appear that reducing the overall rate of detentions is, at best, a secondary focus. Only four of the 154 recommendations in the review directly linked to a desire to reduce the overall detention rate and even those appear conspicuous in their lack of detail and specificity. Recommendation 35 for example, states that: ‘There should be more accessible and responsive mental health crisis services and community-based mental health services that respond to people’s needs and keep them well.’ Whilst this reflects the views of AMHPs in the current study, further information pertaining to *what* would make crisis and community services more accessible and responsive, or indeed how current services fall down in this respect is absent from the final report of the Independent Review. Likewise, the review recommends ‘introducing a new time limit by which a bed must be found following an order for detention’ (Wessely *et al.*, 2018b: 118), however no guidance is given as to what this time limit should be, what should happen if it is breached, or indeed, what additional resources would be required to ensure beds are found within this timescale. To this end the extent that such recommendations are readily implementable is limited.

Implications for policy and practice

Despite acknowledging that a lack of psychiatric beds has made it more likely for hospital admission to be delayed and for discharge to be accelerated, AMHPs did not strongly advocate for more beds to be made available. This is due to recognition that the current mental health system is already overly-reliant on hospitalisation and therefore increasing hospital capacity would not address underlying problems. Instead AMHPs wanted to see greater investment at both ends of the mental health service spectrum.

AMHPs believe that more preventative services, such as day centres, ‘floating’ support staff, or ‘befriending’ opportunities, would help to mitigate the impact of social ‘risk factors’ which lead many people’s mental health to deteriorate. These services would provide people with structured activities, combatting social isolation and loneliness and help people to develop their own support networks and grow their social capital (Webber, 2008). Where possible such services would enable people to pursue more educational, recreational, or employment related opportunities, which evidence has shown to be effective in supporting people with mental health problems to stay well (Harris, 2001; Catty *et al*., 2005). Additional ‘low intensity’ support could also provide people with more practical assistance and advice related to common social stressors – such as debt, housing and benefits. The combined effect of such interventions, would, some AMHPs suggested, reduce the numbers of people presenting to mental health services in crisis.

At the same time AMHPs also felt that there was a significant need to invest in crisis services for those who are experiencing acute distress. AMHPs stressed that there are insufficient amounts of non-medical ‘places of safety’, such as crisis houses, which in certain circumstances would be more appropriate and beneficial for patients than a hospital admission. More investment in these resources would not only enable AMHPs to better align their practice with the MHA principle of least restriction and the duty to maximise patients’ independence, but would also give AMHPs more viable options other than a hospital admission to consider during MHA assessments. Such investment would reduce the chance of being detained.

AMHPs concluded that if the suggestions above were implemented, outcomes for patients would improve and numbers of detentions would reduce and accordingly, reform of the MHA would not be required or advisable.

Study limitations

The qualitative element of this study was small-scale and conducted in only one NHS Trust in an urban area in England. Interviews with AMHPs in a contrasting setting, for example AMHPs working in a rural setting, might have raised different issues or nuanced differences to the same issues. This would help to guard against a potential locality bias in which results are actually representative of a unique local situation. However, the national survey findings largely corroborated themes that emerged in the interviews suggesting a consensus amongst AMHPs. The above could also have been achieved if survey respondents were asked to provide qualitative data in relation to certain questions. However, this was a research project for a Master’s degree and as such was unable to accommodate either more research sites or analysis of qualitative data from survey respondents due to time restraints.

This study has touched on, but been unable to fully explore, a number of topics which may warrant further investigation. In particular, AMHPs have expressed their preference for more non-medical ‘places of safety’, such as crisis houses. Research which examines whether areas with more of these resources detain fewer people than other areas would therefore be instructive. AMHPs also reported that they felt the length of time someone is admitted to hospital in a mental health crisis has reduced over time. Further study which investigated whether the duration of hospital admissions has reduced and whether there is any connection between reduction in length of admission and likelihood of readmission would also help to build the evidence base around the rise in detention rates.

AMHPs involved in this study were not asked to consider the possible reasons why those from Black or Minority Ethnic backgrounds are more likely to be detained under the Mental Health Act. Clearly the issue of over representation of certain ethnic groups in inpatient settings is a major cause of concern, raising questions about both the legitimacy and application of the Mental Health Act in practice. However, this topic was felt to be too large to address in any meaningful way within the constraints of this project – which instead considered the reasons for rising detention rates in general and not the disparity that exits between detention rates among different sections of the population.

**Conclusion**

AMHPs share the Government’s concerns about growing numbers of people being detained under the MHA. They do not however believe that the best way to address this problem is to change mental health legislation. Instead they view the problem of rising detention rates as symptomatic of a bigger issue: an unprecedented and unsustainable demand for mental health services, caused in part by a deterioration in the social structures that help people to stay well, leaving services perilously stretched at precisely the point they are most needed. Within this context, use of the MHA has become an overused last resort, not by design, but by necessity. Rather than make changes to the law, AMHPs favour investment in resources. This investment should directed at both preventative services, such as promoting greater social inclusion and interaction to help reduce the number of people experiencing mental health crises; and acute services, such as increasing the numbers of non-medical and crisis houses, to offer an alternative to hospital admission for those in crisis. It is hoped the combined impact of these changes would lead to a reduction in detentions under the MHA.

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