

Approved Mental Health Professionals' experiences of moral distress: 'Who are we for'?

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Abstract

In England and Wales, Approved Mental Health Professionals (AMHPs) undertake interviews with service users as part of wider Mental Health Act assessments. AMHPs act as the ultimate decision-maker in relation to statutory detentions. They have legal duties to consider the least restrictive outcomes for service users, including alternatives to hospital. Yet they are increasingly unable to act on this, resulting in conflicting pressures. This article draws on a qualitative research study incorporating ethnographic research and interviews with AMHPs. Evidence suggests that service restructures are creating different approaches to practice with contradictory priorities, for example, whether the work is values-driven and relational or whether approbation is attached to a 'need for speed'. AMHPs are increasingly deliberating about what makes 'proper' or 'good' AMHP practice, asking 'who are we *for*?' and referring to their work as 'political activity'. AMHPs' sense-making and language is indicative of moral distress. Organisational politics may lead to the work being seen as a technical-rational endeavour, not a moral one, leading to dissonance. More broadly, AMHPs and service users are, together, bearing the brunt of austerity measures and there are increasing unmet needs. Overall, there is a need to establish an ideological, theoretical and political base for practice.

Keywords: Approved Mental Health Professional (AMHP); Mental Health Act; MHA; MHA Assessment; MHA interview; Moral Distress

Teaser Text

In England and Wales, Approved Mental Health Professionals (AMHPs) undertake interviews with service users in Mental Health Act assessments where decisions are made about detaining service users without their consent. Based on two medical recommendations, AMHPs make the final decisions about whether to detain. They are required to seek less restrictive alternatives to detention or hospital admission but they are, increasingly, unable to do this, leading to a high level of stress and AMHPs leaving the job, understood here as moral distress. This article is based on a qualitative research study incorporating ethnographic research and interviews with AMHPs. Findings suggest that there are increasingly different approaches to AMHP practice, leading to debates about what makes a 'proper AMHP' and whether the work should prioritise relationships with service users. AMHPs asked 'who are we *for*?' They described their work as 'political activity' and this is discussed here, both in terms

of the politics of austerity limiting alternatives to hospital and the organisational politics influencing approaches to practice. The article concludes by suggesting that an evidence base for practice could increasingly be useful to support AMHPs' reflection on their practice.

Introduction and background to the AMHP role

In England and Wales, Approved Mental Health Professionals (AMHPs) have specific roles within mental health legislation. They undertake interviews with service users as part of wider Mental Health Act assessments. AMHPs act as the ultimate decision-maker in relation to statutory detentions. Their legal duties rest on considering the least restrictive outcomes for service users, including alternatives to hospital. The role is, historically, an amalgam of legal, professional, administrative and practical functions (Hargreaves, 2000). AMHPs' independence is fundamental and the role was, from its inception, intended to counterbalance the narrow clinical psychiatric model with a holistic social perspective enabling less restrictive, community-based alternatives to hospital (Gostin, 1975).

Arguably, in statute and in guidance, little has changed from a Local Authority Circular, issued in 1986 and relating to the earlier iteration of the AMHP, that of the Approved Social Worker (ASW) where:

ASWs should have a wider role than reacting to requests for admission to hospital ... and ensuring compliance with the law ... They must be familiar with the day to day working of an integrated mental health service and be able to assess what other services may be required and know how to mobilize them ... Their role is to *prevent the necessity for compulsory admission to hospital* as well as to make application (emphasis added) (LAC (86) 15).

AMHPs have overall responsibility for coordinating the process of assessment (DoH, 2015, para. 14.40). Their role is to:

arrange and coordinate the assessment taking into account all factors to determine if detention in hospital is the best option for the patient or if there is a less restrictive alternative (Explanatory Notes to the Mental Health Act, para.71).

The role has always been wider than a legalistic one. The National Workforce Plan for AMHPs (DHSC, 2019) recognises that the work is fundamentally values-based and oriented to a

human rights approach, with a need to promote service users' dignity, and human and civil rights (6.1).

Overall, there are several domains influencing AMHP work: it is practical and processual, including the coordinating role and attempts to find alternatives to hospital; it is a statutory, legalistic role, requiring expert knowledge of statute; professional aspects of the role involve AMHPs' social perspective, anti-oppressive and anti-discriminatory practice and the requirement to maximise service users' self-determination; moral and ethical dimensions arise from the independence of the role and the need to balance state paternalism; and, finally, the work is relational and interpersonal involving a critical awareness of the use of self in practice (Hemmington and Vicary, 2023).

Guiding principles

AMHPs' professional imperatives have, since 1999 (Department of Health, 1999), been consolidated in statutory guiding principles. The 'least restrictive option' in England states that:

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 para 1.1).

In Wales, the focus is similarly on 'retaining a person's independence and exploring alternatives to admission and least restrictive options' (Welsh Assembly Government, 2016, para. 1.8). These alternatives could 'include informal admission or support in the community, for example from a crisis team or crisis house' (Department of Health, 2015, paras 14.7; 14.11). AMHPs' written summary reports should make clear reference to these principles and how they have been considered (DHSC, 2019).

Policy contexts

AMHP work is taking place within a context of austerity measures. In the UK, the government's agenda has, for over a decade, been to develop a neoliberal transformation of health and welfare services. A damaging consequence for mental health service users has been a divisive rhetoric of 'skivers' and 'strivers', promulgated to drive a wedge between those who experience mental distress and those who do not (Garthwaite, 2011; Moth and McKeown, 2016). The neoliberal agenda has also emphasised mental health professionals' 'responsibilisation'

(particularly their vulnerability to being blamed for failures of risk management) and data monitoring over and above relational aspects of care (Moth, 2022).

A further consequence of government austerity measures has been the reduction in mental health resources within both hospitals and the community and these profoundly impact the AMHP role (CQC, 2016; 2018). Insufficient hospital beds have led to a preponderance of out-of-area bed usage (BMA, 2022) and this continues to be the most problematic area of practice for AMHPs (Hemmington et al, 2021; Morriss, 2016; BASW, 2016; Stevens et al, 2018; Bonnet and Moran, 2020). Simultaneously, in England, there are increasing numbers of applications for detentions (NHS Digital, 2021) and declining numbers of AMHPs (NHS Benchmarking and ADASS, Skills for Care, 2021). Stress amongst AMHPs is high (DHSC, 2021; CQC, 2018) and the inadequate provision of resources, combined with an increase in social stressors and mental ill-health risk factors, leads to a system which is overly reliant on hospitalisation (Hemmington et al, 2021; CQC, 2019). People are being detained by default rather than by necessity (CQC, 2018), detention has become an 'overused last resort' (Bonnet and Moran, 2020) and AMHPs feel 'forced' to detain people in the absence of a less restrictive option (Hemmington et al, 2021; BASW, 2016) all of which runs counter to their professional imperatives.

Further structural inequalities compound these difficulties whereby socio-economic status, and access to social and cultural capital, influence detention rates. This is not new: Hatfield (2008) found low income, poor material resources, social exclusion and isolation and issues such as drug and alcohol misuse were significant. Sheppard (1993) referred to the 'social insecurity' of many service users using similar measures. Compulsory admissions have been viewed as a consequence of a lack of social support as much as an intrinsic need to be in hospital (Barnes et al., 1990). It appears to continue to be the case that the most deprived areas have over three times the rate of detention (NHS Digital, 2021).

Service users' experiences of MHA assessment and detention

MHA assessments are experienced as inherently threatening, deeply unequal, intrusive or, worse, as an ambush, a direct threat or as a means of wielding power (Buckland, 2020; Hemmington et al., 2021). They often have three or even more professionals involved which is experienced as 'daunting', 'intimidating', 'oppressive' and, powerfully, a 'barrage of three' (Blakley et al., 2021). Yet difficult experiences can be mitigated by being heard and respected and by good interpersonal relationships, good communication, being listened to, believed, understood and respected (Blakley et al., 2021; Akther et al., 2019; Katsakou and Priebe, 2007). Service users prioritise empathy, a focus on the relationship, emotional aspects

including warmth and reassurance, and the AMHP offering time and even acting as advocate and 'standing up' for them (Hemmington et al., 2021; Blakley et al., 2021).

Overall, however, there appear to be increasing fundamental, existential problems around what 'good AMHP practice' looks like in a changing landscape. More recently, research undertaken within AMHP services suggests that this is beginning to present itself in escalating moral distress leading to an urgent need for existential reframing and, perhaps, a new form of AMHP work as relational and political activity. This is discussed within a context of research findings, outlined below.

Methods and methodology

A qualitative research project was undertaken in an AMHP service in England. The research was granted ethical approval via the National Health Service Health Research Authority in England and informed consent was obtained from all participants involved in the study. The first phase of this research was a two year-long ethnographic study in different parts of an AMHP service with different geographical settings. The second phase involved individual, semi-structured interviews with the AMHPs who had been involved.

Ethnography

Ethnography involves field study to understand groups (or societies, cultures, or institutions), usually by having the researcher being within and being accepted into the culture, and aspiring to understand and articulate it (O'Reilly, 2012). Being ethnographic with people 'in all their strangeness and in their mundane and quotidian flow' is a valuable way of being able to build a qualitative understanding of the 'particulars and generalities' of the subjects (Madden, 2010, p.32). In organisations, this means trying to understand how, and in what ways, an organisation (and its membership) makes sense of itself (Neyland, 2008). Given the practice contexts, the approach resembled Ferguson's (2014) attempt to achieve 'close up encounters' using 'practice-attached research'. Field notes were gathered in the form of a daily diary. To prepare this ethnographic data for analysis, superordinate themes, and then sub-themes, with sub-headings, were identified using a form of coding and logging (Spradley, 1979). 'Data clumps' included verbatim examples of speech, my representations of events and sub-themes including those such as 'Metaphor', discussed below.

Interviews

With consent, four Mental Health Act assessments were observed and audio-recorded to enable the use of Conversation Analysis (CA) to analyse communicative patterns (see Hemmington, 2023). Post-assessment semi-structured interviews with the four different AMHPs involved were then undertaken. These interviews were planned with a dual purpose: to offer the AMHP an opportunity for debrief and to better understand their perspectives, since 'providing a context for a person to tell their own story is the best way to capture the complexities' (Kalathil, 2011 p. 21). Each interview was around one hour in duration, and was audio-recorded and transcribed verbatim. Braun and Clarke's (2006) Six Phases of Thematic Analysis were used to analyse the data. This involved an initial familiarisation with the data to develop a 'feel' for possible patterns and connections, following which initial codes and themes were generated from working systematically through printed transcripts. Mind-maps and colour-coding enabled the identification of deeper sub-themes. Braun and Clarke's (2012) Reflexive Thematic Analysis approach also meant that explicit attention was paid to the importance of my own interpretations of patterns of meaning underpinning the theoretical assumptions.

Positionality

Qualitative enquiry is not a neutral activity and reflexivity recognises that researchers are inescapably part of the social world that they are researching (Hammersley and Atkinson, 1983). As a reflexive researcher I acknowledged how my social, cultural and disciplinary positioning shaped my narratives (Heapy, 2007). I practice as an AMHP, I am an educator and trainer, and I have other professional roles pertaining to AMHP practice development. Yet in terms of this research, I was both within and external to this AMHP world. Participants inevitably behaved in particular ways in my presence. I noted the ways in which I was interpreting and handling my identities through the way I related to AMHPs, aware of the danger that being immersed might mean that I merely 'find the familiar' (Madden, 2010). Yet the research yielded unexpected results.

Significant themes identified

The research revealed an emerging, unanticipated, picture of power struggles and fissures and a divergence between organisational and individual identities and perspectives within the AMHP service. Ultimately, the locations (that is, the people within them) did not always work together in expected ways. AMHPs articulated their distress in different ways and, ultimately, were evidencing their struggles with some core existential matters.

A crisis of purpose and identity: Who are the ‘proper AMHPs’?

The AMHP services in which this research took place had been undergoing transition and reorganisation in keeping with the national picture of operational restructures (Skills for Care, 2022; DHSC, 2019; ADASS, 2018). A full-time AMHP role had been created and, generally, full-time AMHPs worked alongside mixed-role, part-time AMHPs who, when not on AMHP duty, continued with their community mental health work (usually mental health social work).

In some areas, how assessments were allocated impacted the division of labour in terms of relative workloads. Some AMHPs were undertaking two, three or more MHA assessments per shift whilst others undertook one. Some AMHPs had also begun to perceive a stratified system with inherent power relations. Comparisons were made with having a place in the equivalent of the football ‘Championship’ or having been promoted to the (superior) ‘Premier League’. New existential questions, fundamental to identity, were also being asked as to what constitutes a ‘proper AMHP’ or a ‘good AMHP’. There were passionate conversations amongst full- and part-time AMHPs pertaining to relationships and power. Struggles and tensions arose from the priorities that they ascribed to their work, for example whether it was, or remained, a values-driven, relational venture or whether approbation and ‘good practice’ was attached to a need for speed.

Communication, meaning and the use of metaphor

Other conflicts came into focus through the ways in which AMHPs conveyed their experiences and emotions through language. A recurring observation was of the use of metaphor and figurative language. AMHPs used metaphorical language as a means of understanding, articulating, and diffusing difficult subjective experiences. One repeating theme was with the use of military language, where assessments were ‘planned missions’ and, at the beginning of a shift, an AMHP described having to ‘get my armour on’ which appeared to be indicative of a sense of vulnerability, both physically and emotionally. More generally, AMHPs across the service described ‘battle fatigue’ and some referred to themselves as ‘veterans’.

Ultimately, AMHPs used metaphoric and figurative language to describe elements of situations that were otherwise unaccounted for – tacit knowledge, where there are no written references that could explain or validate their feelings or experiences. Their subjective interpretations could be controversial, not least where they brought them into contention with their peers or

where they were not aligned with their aspirations to work in partnership with service users. They were also often hard to convey, so the use of metaphorical language enabled them to frame the topic in different ways, foregrounding what was important and making it real, apparent and spoken out loud (Bowker, 2009). It enabled them to, at times, bond quickly and strongly and to share complex emotions, integrating experiences safely and productively (Young, 2008).

An existential crisis: who are we for?

AMHPs' introspection continued in the interview phase of the study. Tensions surrounding their purpose and identities arose frequently. AMHPs' competing and overlapping identities have been noted elsewhere (Quirk et al, 2000; Leah, 2020) and AMHPs in this study acknowledged the complex, multiple aspects of the work:

Sometimes you're debating the law, sometimes your buttons get pushed around values and ... sometimes you get into work not knowing which 'head' you're going to put on ... Local Authority social worker, mental health practitioner/clinician, legal expert, advocate or activist standing up for the vulnerable and oppressed ... I mean, who are we there for, really? Who are we for?

This AMHP takes critical evaluation a step further by asking a question as fundamental as 'who are we for'. A further existential question about the profession, it was in keeping with a perception of AMHP work as relational work.

AMHPs often attributed stress attached to their work as being derived from the lack of resources. All made some direct or indirect reference to feelings of guilt and failure arising from having to leave people in distress:

I'm supposed to go out and solve problems but you're never going to feel good about this. It used to be [that] detaining people made you feel pretty shit ... now it's leaving people who are struggling – saying 'yeah life IS all awful for you, bye then' and that makes you feel worse and like you've failed at every turn.

There were powerful, visceral descriptions of the work which were, however, delivered in matter-of-fact terms. AMHPs don't necessarily engage with their own trauma arising from the work they do. One viewed their role in graphic terms:

You talk to people and make a judgement about their soul, their very being, their existence and then what? You've got a responsibility to transport them to some sort of

new life or afterlife whether they want that or not and whether they want to be changed or not ... like some sort of Psychopomp shit ... who am I to do that?

This was extraordinarily deep reflection, with 'Psychopomp' being applied in a context of religious or Shamanic cultural beliefs where the Psychopomp guides newly deceased souls to the afterlife. Again, by asking '*who am I to do that?*' the AMHP is reflecting on their inherent power and the consequences of their decision-making. Thompson (1997) highlighted that 'compulsory admission to hospital ... is often traumatic for ASWs ... if they have any sensitivity' (p.43) and yet twenty-five years later this remains poorly acknowledged in the literature and in practice.

AMHP work as 'political activity'

Throughout the research, AMHP work was referred to as 'political activity'. At its simplest, this meant the adoption of a values-based, rights-based, justice-focused approach, including seeking alternatives to hospital or challenging discrimination or oppression as a form of advocacy. One AMHP suggested that their collective noun should be that of a 'necessary irritant' reflecting the need to challenge or disrupt systems as a form of advocacy. It related to the ways in which AMHPs understood the power relations, the structural, macro- and micro-institutional policy structures, as well as the micro-relational, communicative aspects of the work. The politics of AMHPs' work can be evaluated in different ways.

The politics of organisations

Carrying several MHA assessments simultaneously and the 'need for speed' scenario suggests that, for some, AMHP work has become a technical-rational endeavour when it is arguably a moral and ethical one. There is growing dissonance between the original ethical impulse that brought people into the work and the job they are increasingly expected to do (Smith, 2011). The AMHPs who ask '*who are we for*' reflect Bauman's (1997) position that their ethical stance is that they should 'be for' those they work with. This, in turn, relies on them taking personalised and situated moral positions. AMHPs were also articulating the type of 'social suffering' identified by Bourdieu et al. (1999) as being the gulf between workers' occupational realities and their more deeply held ontological and professional beliefs. An organisational culture of managerialism is characterised by efficiency, economy, targets and performance indicators and AMHPs, who were critiquing the value attached to speed, were experiencing stress (or distress) through the misalignment of organisational values and their individual values (Rajan-Rankin, 2014).

These findings were in keeping with the broader national picture of an apparently increasing separation of styles of practice, in terms of whether AMHP work is merely functional, processual and legalistic, or whether it is more allied to relationship-based, person-centred work. Elsewhere, AMHPs have reported that their services, as a consequence of workload, were developing troubling cultures wherein the work had become ‘an exercise in who can do it the quickest’, and that there was a ‘macho’ environment where attempts to slow down and discuss aspects of practice were met with a ‘JFDI’ (the vernacular abbreviation for ‘just fucking do it’) and a ‘man up’ response (Hemmington et al, 2021 p.60). Observations such as this are met, for some, with regret and a reflection on an ideal, and potentially unattainable, style of relational practice.

The politics of relationships

AMHPs appeared to value the opportunity to build relationships with service users but were observing that this is not accommodated within a managerialist culture where deadlines take precedence. They appeared to be arguing for a more explicit reorientation away from a culture of managerialism towards a culture of relationships specifically (Dwyer, 2012) and across mental health care more generally (Moth, 2022). This means being explicit about what the role ought to be. AMHPs have seen themselves as advocates who ‘stand up for the vulnerable’ and who play a ‘Lone Ranger’ part, challenging injustice and bringing order to chaos (Gregor, 2010). Similarly, there has long been an underlying assumption, or expectation, that the AMHP will be ‘the voice of the powerless in the context of an increasingly bureaucratized society’ (Prior, 1992). Many AMHPs in this study were alert to the compromising of this advocacy role.

Overall, AMHPs’ stress and discord happened at the juncture between professional, legal and policy-based aspirations and the actual, everyday enactment of the role. With no clear mode of practice and, rather, the appearance of diverging roles with a growth in tacit practices, AMHPs seem to have been left to wrestle with an endless stream of dilemmas and, increasingly, distress.

AMHPs and moral distress

AMHPs’ inability to meet service users’ needs creating stress and affecting morale has been identified (CQC, 2018; Skills for Care, 2018). They experience guilt and anxiety from having to ‘walk away’ from people in need (Vicary et al, 2019) and their thwarted attempts to prevent admission leads to profound emotional and moral difficulties (Abbott, 2021; Morriss, 2016).

AMHPs' social perspective, which is rights-based and justice-focused, is undermined or eroded by systemic conditions leaving no alternatives to admission (Karban et al, 2021). They seek social justice but are now 'oppressing people' and are placed in 'morally dubious situations', carrying a sense of guilt about the role they are 'pushed' into pursuing (Hemmington et al, 2021).

The occupational psychic strain on AMHPs in this study represented a form of moral injury or moral distress. This arises when constraints make it impossible to do the 'right thing' and professionals perpetrate, fail to prevent, or witness events that contradict their deeply held moral beliefs and expectations (Jameton, 1984). Moral distress develops in a situation 'when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action' (Jameton, 1984, p. 6). Wilkinson (1988) added 'psychological disequilibrium', defined as a:

negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision (p. 16).

Certainly, AMHPs in this study were evidencing a form of psychological disequilibrium.

Moral distress and the politics of resources

Previous research has indicated that applying for service users' detention in the absence of alternative resources feels like a 'personal failure' (Kinney, 2009). AMHPs lament their being seen to provide only a 'sectioning service' at the expense of therapeutic work (Webber, 2013), a sentiment similarly expressed in this study where one AMHP suggested that the AMHP is seen as 'Sections-R-Us' where detention can simply be requested. AMHPs struggle to uphold a service where control and containment are prioritised over treatment and care (CQC, 2016). They are challenged by the exercising of legal powers in an unjust mental health system, evidenced by racial disparities in compulsory admissions and by higher rates of detention in more deprived areas (Abbott, 2021; NHS Digital, 2021; Webber and Huxley, 2004). Aspirations and principles have increasingly not been realised as AMHPs, who are themselves powerless, cannot easily empower others (Prior, 1992). Further, insufficient resourcing, including lack of time and personnel, is also connected to a greater desire to leave and a higher level of sickness absence (Mänttari-van der Kuip, 2015; Källemark et al., 2004) - a finding with clear import for the AMHP workforce, where there have been longstanding recruitment and retention difficulties (DHSC, 2018; Skills for Care, 2018; Huxley 2005).

The challenging search for an AMHP theory base

AMHPs' professional imperatives are, fundamentally, to avoid detention and to find less oppressive forms of care. They view their social perspectives as understanding service users' difficulties as being, at least in part, socially derived, as well as simultaneously recognising the politics of austerity limiting the availability of resources (Hemmington et al, 2021; Karban et al, 2021). Arguably their positions mirror Sedgwick's (1982) view of mental illness: that it is not simply a social construction, but neither is it that which can only be represented by a narrow biological or medical psychiatric approach.

Spandler and Poursanidou (2019) highlight the unhelpful binary oppositions within mental health settings (physical/mental; social/medical and psychiatry/antipsychiatry). Their call for an ambivalent position accommodates AMHPs' angst and their lack of clear framework within which to work. In keeping with AMHPs' work as 'political activity', they recommend explicitly 'unsettling' or 'troubling' these binary oppositions. Arguably, this reflects AMHPs' general perspectives whereby acute suffering is acknowledged as real, but it cannot simply be reduced or resolved by psychiatric intervention (Spandler and Anderson, 2015). Neither, indeed, can it exclude people who believe that psychiatric support, medication, or intervention is needed or works for them (Beresford, 2002).

The politics of choice

In many respects, AMHPs and service users are troubled by the same things: the lack of alternatives to hospital alongside their experience that, when psychiatric hospital beds *can* be found, they can be unpleasant, unhelpful and potentially unsafe environments to be in (Morriss, 2016; Hemmington et al, 2021; Spandler and Poursanidou, 2019). AMHPs and service users alike experience ambivalence in this sphere, albeit in different ways. The national AMHP workforce plan (DHSC, 2019) speaks of services being coproduced however as Dzur (2020) has noted, the path toward coproduction has been complicated by the history of professional-citizen relations where professionals have not just failed to solve problems of engagement but have arguably contributed to it. The consequences of iatrogenic harms include distrust, fear, isolation and secrecy and, even as they have tried to help, professionals have created institutions that can be profoundly disempowering.

AMHPs have recognised their own liminal, ill-defined role (Morriss, 2016; Stevens et al., 2018; Gregor, 2010). Increasingly, their moral distress, feelings of failure to meet need and ambivalence as to who they are 'for' is consistent with an alternative form of resistance borne out of an increasing recognition of psychiatric neglect (Spandler, 2016) where service users are increasingly enduring unmet needs in the face of a right to treatment and support. Sedgwick's (1982) call for 'more and better psychiatry' as opposed to an 'anti-psychiatry' stance – by which he meant different forms of care, but available at scale and state funded (Spandler et al, 2016) - is consistent with AMHPs' search for meaning.

The current political context is one of a contraction of services as a consequence of a government with neoliberal ideologies and a political economy of austerity. AMHPs are not working in a system with a political stance of neutrality. From this perspective there can be limited optimism that they will be in any other position than having to continue to act with powers that are rhetorical and illusory, and in which their experiences of moral distress will continue.

When embedded within a political context of severe restrictions on resources, there is a risk of a perception of abandonment of the person AMHPs are there to empower or, from a state paternalism position, protect. It is this sense in which AMHPs could refocus the meaning of their self-observed 'political activity' to further consider matters of allyship in their approach to advocacy. Closer consideration could be given to the ways in which AMHPs can enact their work more democratically and aspire to a system that is relational and, as far as is possible, consensual.

Compulsory detention may still be necessary at times, but Spandler and Poursanidou (2019) advocate an approach that is context dependent, where a person's unique needs and situation are balanced. This necessitates a recalibrating of the traditional focus on diagnosis and treatment with prioritisation given to personal and self-determined perspectives and choice. The crucial challenge, however, is to provide choice that is relevant (Piasecki and Hanna, 2011). Caton and Kilyon (2023), speaking from a position of lived experience of assessment and detention, discuss their striving to campaign for changes to the mental health system to incorporate healing, and respectful and non-compulsive ways of working. This may reasonably include hospital admissions, but ones with a less distressing environment and ones which people might choose to be in – which of itself might reduce rates of compulsion.

Future considerations

Standard Four of the National Workforce Plan for AMHPs (DHSC, 2019) states that AMHP services should 'ensure that AMHPs' safety and well-being is at the forefront of operational

considerations' (para. 4.1). Additionally, services should 'promote a culture of open and honest communication' (para. 4.5). Arguably, this invites consideration as to whether AMHP services are based on cultures of managerialism, where deadlines take precedence, or cultures of relationship-building, advocacy and AMHP work as political activity. Fundamentally, if the emotional backcloth of an organisational culture is one that views high stress levels as a normalised, innate aspect of the work, then there is a risk of it remaining unchallenged (Rajan-Rankin, 2014).

AMHPs are experiencing apparent paradoxes and dilemmas from servicing an ostensibly oppressive system but holding to a (more radical?) social perspective. Resources will always be limited to a lesser or greater degree, but if AMHPs follow their professional and moral codes they cannot remain silent. The alternative to exiting is to raise voices. Viewing AMHP work as political activity, striving for 'proper AMHP' work and asking 'who are we *for*?' is to recognise our moral distress but also to see it simultaneously as a source of motivation for the exercise of our moral agency (Lützén and Kvist, 2012). Certainly, increasing experiences of moral injury do seem to be indicating a pendulum swing in this direction.

Limitations

The study was relatively small-scale and, as such, may be considered a pilot for future work. Additionally, my close proximity to the work means that I inevitably identify with AMHPs in this study and my interpretations may, at times, reflect this. Whether or not this is wholly a research limitation, a level of reflexivity is essential. Research such as this brings with it a position of liminality, in that the researcher is in-between practitioner and researcher, requiring the reconciliation of detailed practice knowledge and research ethics. Again a potential limitation, this also invites further practitioner-research in the AMHP world.

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