Facilitating the 'Least Restrictive Option and Maximising Independence' under Section 115 Mental Health Act 1983

Rachael Rooke

One of the main responsibilities of the Approved Mental Health Professional (AMHP) is coordinating Mental Health Act (MHA) Assessments. This can include making applications for compulsory admission, and applying the guiding principles of the MHA including, the 'Least restrictive option and maximising independence' when considering alternatives to compulsory admission. A MHA assessment is usually requested during mental health crisis when alternatives to admission are exhausted. Literature refers to the controlling and coercive elements of the AMHP role, lack of community resources, and the increasing number of compulsory admissions direct from the community. There is less research on the wider role of the AMHP and its potential to avert crisis. Included in the main AMHP functions is the authority under section 115 MHA to enter and inspect, with 'reasonable cause', premises in relation to 'mentally disordered patients'. This authority may enable AMHPs to intervene without coordinating a MHA assessment whilst meeting the legal obligation to 'consider the patient's case' under Section 13 (1) MHA. The role of the AMHP as a 'legal protector' of human rights and their expertise in averting crisis is discussed. This article concludes with recommendations for AMHP practice.

Keywords: approved mental health professional; Mental Health Act assessments; least restrictive; Section 115 MHA

Role of the AMHP

AMHPs are independent public authorities approved to act in the role by and on behalf of local authority social services departments. The Mental Health Act (2007) amended the Mental Health Act (1983); henceforth referred to as the 'Act', replacing the role of Approved Social Worker (ASW), with that of the AMHP, allowing for appropriately registered nurses, occupational therapists and psychologists to qualify and practice in this role (DoH, 2008, 3 and 4). Despite the change in law, the majority of AMHPs are registered social workers

(DoH, 2016, 17) with post qualifying experience of at least two years practice (DoHSC, 2019, 15).

The AMHP role has various functions, but is most commonly associated with coordinating MHA assessments and making applications for compulsory admission when needed, following interview and consultation with the patient, a term used henceforth when referring to recipients of mental health services, acknowledging this as the generally preferred term (Costa et al. 2019, 13). Less discussed, are the other functions of the AMHP role, which include 'powers of entry and inspection' under section 115 MHA (DoH, 2015b, 300).

The Wider Role of the AMHP

Following consultation with ASWs, the 1995 MHA Commission stated; 'the ASW's role should be wider than merely responding to crisis requests for admission, whilst at the same time, the ASW's role appears to have become constricted by increasing emphasis on 'completing forms', and 'statutory duties' (MHA Commission, 1995 in Thompson 1997, 58). According to Thompson (1997, 59), included in this wider role is the authority of section 115 MHA, which states:

> An [AMHP] may at all reasonable times enter and inspect any premises (other than a hospital) in which a mentally disordered patient is living, if he has reasonable cause to believe that the patient is not under proper care (MHA 1983).

The wording of section 115 indicates it is not concerned with the making of applications for detention under the Act, unlike section 13(1). The focus appears to be on the patient's mental wellbeing, and the AMHP's authority to enter and inspect, if permitted to do so. Elsewhere, section 115 is cited as a means of *'gaining access to an adult suspected to be at risk of neglect or abuse'* in relation to adult safeguarding under the Care Act 2014 (Social Care Institute for Excellence, 2018). The scope of section 115 does not authorise forced entry, nor is it applicable to hospitals. There is no explicit expectation that exercising the authority of section 115 will inevitably lead to coordination of a MHA assessment.

As stated by Jones (2019, 525), the wording 'mentally disordered patient', 'suggests that [section 115] can only be invoked in respect of persons who have been diagnosed as being mentally disordered'. This invites consideration as to whether the authority of section 115 can be utilised by AMHPs under the principle of least restriction, in their work with patients known to community mental health services, who have been, or are likely to be, referred for assessments under the Act.

Least Restrictive Alternative and Maximising Independence

Professionals responsible for undertaking functions under the Act (DoH, 2015a, 12), with reference to patient care, support and treatment, have a duty to do so with consideration and understanding of the guiding principles of the Act (DoH, 2015a, 22). The initial guidance offered to achieving the first of these, that is, the 'Least restrictive option and maximising independence', is where possible, to treat patients without the need for detention, in a safe and lawful manner. Additionally, mental health agencies should work collaboratively to provide early intervention services that are equally as effective and available as the services accessed in physical health emergencies (DoH, 2015a, 23). Possible alternatives to admission might include; support from a CMHT (Community Mental Health Team), referral to a Crisis Resolution and Home Treatment Team (CRHTT), or intensive interventions from Assertive Outreach Teams (AOT). The challenge is that many of these services struggle to recruit and retain experienced mental health professionals (Gilburt 2015, 14; Addicott et al. 2015, 27), impacting on their ability to respond as intended. AOTs target those diagnosed with a serious mental disorder and deemed difficult to engage, whilst being most at risk of multiple compulsory admissions (Douglass and Hurtado 2013, 30). The majority of AOTs have been disbanded and subsumed into existing services (McNicoll, 2013), and evidence suggests that merged services have recorded increased suicide rates, compared to areas that have retained distinct specialist services (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2013, 3). CRHTTs were proposed as a less restrictive alternative to in-patient admission for people experiencing mental health crisis (Lloyd-Evans & Johnson, 2014). Evidence suggests that these services can be effective in reducing admissions (Carpenter et al. 2013, 236), nevertheless results from a recent survey state that implementation of the CRHT model is 'highly variable', and the majority of crisis services do not fully implement the recommended model in accordance with national guidance (Lloyd-Evans et al. 2018, 146).

These issues are not contained to community services. The 2018 review of the Act clearly summarises the main issues affecting inpatient teams; increased use of the MHA and compulsory admissions (DoHSC, 2018, 49), of which black people continue to be disproportionately affected (Littlewood 1986, 306; Care Quality Commission 2019, 11), and various other traumas associated with admission. There is an expectation within the Act and the accompanying code, even when patients do not agree, that compulsory admission and subsequent intervention will be beneficial to them (Priebe et al. 2011, 378), although this is not always so. Patients, in collaboration with the National Collaborating Centre for Mental Health (2012, 131-135) describe the ward as boring, isolative or frightening. In some instances, not knowing whether they had been detained under the Act until they were prevented from leaving the ward, and experiencing control and restraint in the

administration of forced medication, which did not address the source of mental distress, for example, abuse and other traumas. Akther *et al* (2019, 1–7) confirm the persistence of similar issues including fear for personal safety in communal areas, loss of normality, and feeling worse on discharge due to the ward experience. Whilst some patients felt admission was unavoidable, others felt theirs were preventable, had there been access to adequate community support (DoHSC, 2018, 105).

The review of the Act states that 'AMHPs have a specific responsibility within the regulation of their profession to consider least restriction and alternatives to detention as part of the assessment' (DoHSC, 2018, 104). The suitability of, and satisfaction with the outcome, following consideration depends on the 'alternatives' available; the benefit of considering least restriction is lost if adequate service provision is under-resourced or non-existent. Barriers to the material application of the least restrictive option come in the form of austerity policies that have effected permanent changes to UK welfare provision since the financial crash of 2008, and to the detriment of groups most in need (Rice-Oxley 2019). This includes those unable to seek or maintain gainful employment due to severe mental health needs or the barriers faced because of their health needs (Cummins 2018, 4). Ramon (2007, 1) discusses the established consensus linking poverty and mental illness, therefore it seems apparent, in the wake of the recession following 2008, that those already impoverished and experiencing mental ill health, may be subject to increased hardship. Demand for mental health services have increased due to needs relating to socioeconomic factors including homelessness, loneliness, reduction in local service provision, and financial pressures (Evans 2018, 8). Poverty and mental illness combined, serve to perpetuate socioeconomic disadvantage, inequality and emotional distress (Karban 2016, 893). Increasingly on hand to exacerbate this state of affairs, is the application of the medical model (manifest in compulsory admission for medical treatment), to what is likely a stress reaction to complex and grinding social issues.

Professional Tensions

A source of referrals for MHA assessments are other mental health professionals, working in close proximity to the patient. The AMHP's considerations and enquiries of the least restrictive option, that is, alternatives to compulsory admission, may lead to contention between said referrer, and the AMHP, particularly when the referrer believes detention is a foregone conclusion, notwithstanding completion of the assessment. Matters rarely improve if the AMHP reminds the referrer of their duty to 'consider the patient's case' under section 13(1) MHA, but being an independent authority, they cannot be forced to make an application. Add to this the difficulties in securing a second doctor to complete the assessment during daytime hours (DoHSC, 2018, 217), and the

lack of suitable inpatient beds (McNicoll 2015). Finally, the issues are compounded by delays in conveying patients safely once an application can be made. It is clear to those with experience of the process, that a MHA assessment has the potential to distress all concerned, particularly the patient and those who care about them.

Current experience of service provision needs to improve for patients, their personal acquaintances, and the professionals involved. Furthermore, this article asserts that AMHPs, in their wider role, can contribute to the solution. NHS England has shared its plan to modernise community based mental health services (NHS England and NHS Improvement and the National Collaborating Central for Mental Health, 2019, 9 and 10) but it lacks explicit reference to the role of the AMHP. The review of the Act makes recommendations to facilitate 'least restriction' (DoHSC, 2018, 23) but without reference to how AMHPs may affect this in their wider role, not just from the point of referral for an assessment. It does however, under the theme of 'staffing' state that the '[AMHP] is responsible for making applications for detention' (DoHSC, 2018, 216). A possible interpretation of this is that AMHPs are specifically associated with crisis and mental health emergency, the reactive and controlling aspects of the MHA, though this would be a narrow interpretation of the role. A more realistic and informed analysis is provided by Leah (2019, 7), evidencing the numerous and overlapping manifestations of the role, including 'advocate' and 'educator'. The review of the Act does not consider that many AMHPs are also Care Coordinators; these are usually social workers, nurses and occupational therapists responsible for coordinating and reviewing patient care within secondary mental health services (Hannigan et al. 2018, 2). The review appears to reference the role of Care Coordinator only once in its key terms; there is no obvious acknowledgement that the same professional can undertake the role of AMHP and Care Coordinator, and consequently, there is no acknowledgement of the wider role of the AMHP, which can be utilised to avert assessment and/or compulsory admission.

Upholding Article Five Human Rights

The patient's right to liberty and security is enshrined in Article five of the ECHR (European Convention on Human Rights) (Equality and Human Rights Commission, 2018), and passed into UK law as the Human Rights Act 1998. Save for the archaic terminology in subsection 1(e) authorising the detention of 'persons of unsound mind' (HRA, 1998), Article five is a key driver of the least restrictive option in MHA assessments. It incorporates the principle of proportionality, directing public bodies to undertake necessary actions, and no more (CPS 2019). In practice however, AMHPs need to overcome several barriers to adhere to the ECHR and application of the least restrictive option, not only depleted community services, as discussed, but also the context and

timing of a MHA assessment. Short timescales and emotional turmoil are not especially conducive to thorough interview with the patient or consultation with relatives (Dixon et al. 2019, 305), less so when in the patient's home. MHA assessments can commence at short notice, due to emergency or agency pressures. Often one of the two medical recommendations fundamental to the process of many MHA assessments is already complete, without the AMHP or the second doctor present, meaning the process of assessment has begun, and is time bound by the Act permitting not more than five days between doctors' examinations. This affects the time available to the AMHP to consider the least restrictive option (Wickersham et al. 2019, 12).

Application of section 115 may be utilised to adjourn progression to more formal proceedings, allowing sufficient time to meet and discuss with the patient their current circumstances, wishes and feelings. Section 115 allows for this if patients are known to community mental health services, establishing an opportunity for meaningful, non-tokenistic, shared-decision making, minus the presence of doctors who in theory, and not unexpectedly, may approach the assessment from a medical, rather than social model of disability (Beresford et al., 2010). Shared-decision making is dependent on a shift in power and control between medical professionals and patients (Glyn et al. 2017, 1), ultimately reaching decisions together about the patient's health needs. The value of this approach has been inconsistent in psychiatry (Hamann, Leucht, and Kissling 2003, 403), however, recent proponents of shared-decision making in mental health state the importance of recognising patient narrative as no less superior to the clinical knowledge of practitioners. Doing so enriches and informs the decisions made and ensures they are in the interests of the patient (Bergqvist 2020, 5). The AMHP's consideration of the social perspective can bridge the patient and medical perspectives, more so when there is time to harness a comprehensive patient narrative. Contrary to popular belief, AMHPs do not only make applications for detention and it does not always feel like 'dirty work' (Morriss 2016, 704 and 705). If AMHPs can utilise section 115 in conjunction with patients, their personal acquaintances, and other mental health services, AMHPs may realise the potential to act as 'custodian of social justice' (Leah 2019, 10 and 11), providing the opportunity to promote the patient's human rights and address their needs with them, in partnership, in their community.

Opportunities to Apply the Principle of Least Restriction

When AMHPs undertake other roles, such as Care Coordinator, social worker etc. such roles can offer important 'touch points' where opportunities for promoting less restrictive alternatives can be effected (Dewar et al. 2010, 31). Notwithstanding concerns about damaging the therapeutic relationship and availability, Care Coordinators who are AMHPs can coordinate assessments of their own patients. However, they may also apply less restrictive options in a

relapse stage when early warning signs are present, specifically to avoid coordinating an assessment of their own patient under the Act. The AMHP qualified Care Coordinator and patient should, under the Care Programme Approach, complete a care plan and risk assessment together, identifying strengths, signs of relapse, a crisis plan, and useful contacts (Kingdon 1994, 41). The AMHP qualified Care-Coordinator, in this scenario, with the patient, should then work in partnership to meet their identified needs and wishes as documented in the care plan, but also endeavour to intervene as soon as possible when signs of relapse manifest. This is not a suggestion that Care Coordinators who are not AMHPs do not practice to prevent relapse or MHA assessments; it is merely to enforce an ethical and moral consideration, that whilst discharging the role of Care Coordinator, the AMHP's obligation to adhere to the guiding principles of the MHA and uphold the patient's human rights should apply concurrently. Two anonymised case studies will be considered, the first of which intends to illustrate practice under the principle of least restriction and maximising independence, and the second, additionally relates to suggested application of section 115.

Case Illustration One

Gina has a longstanding diagnosis of schizoaffective disorder and I was her allocated Care Coordinator. During our time working together, she told me about herself, including her mental health. We used the information she provided to complete a care plan and risk assessment. The documents included a section about her family, her definition of what good mental health meant to her, and signs that might indicate her mental health was not as good as she would like. In our conversations, Gina asserted that she never wanted to be 'sectioned' again; she had a history of detention under the Act and remained traumatised by the experience.

Gina experienced changes in behaviour when her mental health deteriorated, and consequently her son would contact me to express concerns about his mother's mental health and personal safety. In response, I alerted Gina to changes in her behaviour with reference to her care plan. The nature of our therapeutic relationship allowed us to discuss her son's concerns, her experiences and perspective, and agree actions to avoid further deterioration. Sometimes increasing my contact, medication reviews, or respite were sufficient to avert crises, but sometimes not. At these times, due to her experiences, Gina would never request psychiatric admission, and when after considering all community options, I suggested a voluntary admission, she was understandably reluctant. We discussed possible interventions should her mental health continue to deteriorate, including a MHA assessment and compulsory admission, which I knew she absolutely did not want. Addressing Gina's health needs early allowed her time to consider her options and consult her

son's opinion, which she valued, and so with his support, Gina made the decision to choose a voluntary admission.

Discussion

There is a gap in research as to whether qualifying as an AMHP enhances the ability to undertake the role of Care Coordinator. Again, this is not at all to cast aspersions about the abilities of mental health colleagues who are not AMHPs, it is only to make the point that completing the AMHP training, as with any advanced training programme, results in deeper learning. Despite the paucity of evidence, one inference to make is that practicing AMHP qualified Care Coordinators are experienced professionals, adept at navigating between community and inpatient settings (Hatfield 2007, 1555). In fact, data indicates the majority of AMHPs have at least three years post qualifying experience (Skills for Care, 2019, 10). This is important to note, as the highest portion of referrals, 29 percent, are reportedly from CMHTs (ADASS, 2018, 50). This generates curiosity about whether there is a way for community mental health patients, where there is an increased likelihood of referral for assessment under the Act, to benefit from the wider role of the AMHP when their Care Coordinator is not qualified as such. I will use the following case illustration to develop this idea. Building on Thompson's work (1997), the second example relates to my time working in a full-time assessment service, and demonstrates how section 115 may be utilised to apply the principle of the least restrictive option and maximising independence.

Case Illustration Two

Joe has a diagnosis of schizophrenia and his engagement with the CMHT was sporadic, as it was with all other health and social care services. Joe has a history of misusing illicit substances, which affected his physical health. He was unable or unwilling to abstain from injecting illicit substances but nonetheless, Joe's Care Coordinator believed he was accepting interventions to address the resulting physical health needs. More recently, it transpired that Joe had stopped taking medication prescribed for his mental health, and had completely disengaged from physical and mental health services, resulting in Joe's Care Coordinator making a referral for a MHA assessment. On further discussion with the Care Coordinator and Joe's psychiatrist, their conviction that a MHA assessment was necessary wavered (but did not completely diminish) and both professionals agreed with my suggestion to visit Joe the following day with an AMHP colleague. My intention was to utilise section 115 to assess Joe's circumstances and consider the referral as per my obligations under section 13(1) MHA. We spoke with Joe, explaining our role, the purpose of our

visit, and our motivation to address the reported issues with him, in the least restrictive way possible. We, including Joe, agreed a plan; he would keep the new appointment made with physical health services, and confirmed his understanding of the contingency should he change his mind; that is, to request a GP domiciliary visit. I relayed this outcome to the Care Coordinator who arranged regular community support for Joe to keep his physical health appointments, which he did and so the referral for a MHA assessment was withdrawn.

Discussion

Joe's case illustrates how our intervention averted the need for a formal assessment and enabled us to consider the least restrictive option, without the stress associated with a MHA assessment. We promoted Joe's Article five rights whilst ensuring he received the service needed. We were honest with Joe about the reason for our visit, and also about what we had been asked to do but it was refreshing to have the opportunity to meet with Joe, acknowledge his views about past admissions, and seek to work with him to avoid a full MHA assessment and compulsory admission where possible. Meeting with Joe following the referral provided a compromise to the tensions that may occur between referrers and AMHPs. In practice, AMHPs might advise the referrer to attempt other, less restrictive interventions before an assessment is coordinated. This may result in the referrer feeling their professional opinion has been undervalued and a belief that the AMHP has not grasped the severity of the patient's circumstances. Visiting the patient, under the authority of section 115, when it is appropriate and safe to do so, is a clear indication that the AMHP is seriously considering the referral and reported concerns, whilst upholding the principle of least restriction and the patient's human rights. If a MHA assessment is indicated after all, the AMHP has a clearer idea of the situation and can have a more informed liaison with the patient, their personal acquaintances, doctors and bed managers. If an assessment is not indicated, the AMHP can contribute to the community care plan.

AMHPs, especially full-time AMHPs, are experienced mental health professionals. Full-time AMHP services are a more recent initiative aimed at meeting the Local Authority's obligation to provide a twenty-four hour service. AMHP hubs allow a greater degree of flexibility and some referrals can be approached with less haste. Our visit under the authority of section 115, allowed application of the wider role of the AMHP, obviating further involvement of the psychiatrist, and independent doctor. Despite the financial and social benefits, such interventions are not captured in national statistics. Currently, applications for detention are the only actions directly related to AMHP interventions recognised in official data. Doubtless, many AMHPs will undertake the type of work we did with Joe but there is no evidence to

confirm this, which means there is no record of good practice when assessment or compulsory admission is averted by the AMHP's intervention. Wickersham et al. (2019, 17) also found that 40 percent of AMHP reports were missing from the 'not detained group', compared with 14 percent of missing reports related to people who had been detained. This finding may point to the lack of value placed by AMHPs on these interventions and is an area that would benefit from further research. Utilising section 115 as described may be a means to formally record this type of intervention and an opportunity to highlight and recognise the wider, less controlling role of the AMHP.

Application to Practice

Utilising section 115 is an opportunity for AMHPs to work in a different and merited way, in conjunction with secondary community mental health services. Unsurprisingly, due to agency pressures and the perceived function of the AMHP, it may seem to other practitioners working in CMHTs, that AMHPs can only be consulted when a patient is in absolute crisis. A suggestion could be for mental health workers to consider consulting with AMHPs at an earlier stage, prior to significant deterioration, and for AMHPs to be available and willingly involved. The benefits of taking a joined-up proactive approach with local CMHTs, under the integration agenda certainly offer ways to respond creatively and efficiently. The approach advocated may be beneficial to patients and could contribute to a reduction in the currently high volume of assessments and detention under the Act. However, clearly it is not feasible for AMHPs to apply this approach to every referral and each one should be considered on an individual basis. It should be noted; the application of section 115 as described, relates to referrals where no significant risk to persons or property was reported, and the AMHP determined that a full MHA assessment was not the least restrictive option, in consideration of the referral information.

Potential Limitations to This Approach

The proposal for utilising section 115 in this way may seem idealistic, but having applied it to individual cases, the benefits should be apparent, even if the outcome is not formally acknowledged. There is limited research on the application of section 115 from an AMHP or patient perspective; further investigation is necessary to ascertain the extent to which it can apply to the principle of least restriction and maximising independence. Other limitations include the diminishing AMHP population, lack of time and opportunity, risk of violence, absconding, or severity of mental health emergency. These are just some of the limitations considered and the approach is not a suggested replacement for MHA assessments. There will always be circumstances where

MHA assessments must be coordinated and the AMHP, although required to exercise independent judgement (DoH, 2015a, 122), would need sound rationale for not doing so.

Conclusion

AMHPs do not feature in the literature as part of the solution to the current mental health crisis despite their breadth of experience working in mental health services. AMHPs are often perceived as the professionals to consult when all other options are exhausted however, AMHPs are currently unable to undertake their role efficiently due to austerity measures (McNicoll 2016). The least restrictive option is an important safeguard for patients known to community mental health services, particularly when applied as soon as patients or their Care Coordinators have concerns, with a view to precluding a MHA assessment or compulsory admission. The review of the MHA proposes revised principles to underpin the Act including 'choice and autonomy … least restriction … therapeutic benefit … people as individuals' (BASW 2019, 2). It is difficult to envisage how these will be realised any differently to the current principles, without resources and time to apply them in practice (Bonnet and Moran 2020, 16). The principle of least restriction and maximising independence may be at risk of becoming a relative concept if all roads, following the decimation of community resources, inevitably lead to a MHA assessment and compulsory admission.

Community assessments under the Act occur when the patient is in mental health crisis (Dwyer 2012, 341 and 342). This article proposes utilising section 115 as a means of applying the principle of least restriction at a time when it can be most effective, that is, following raised concerns for patients known to community services, but before a full MHA assessment becomes necessary. Additionally, I perceive utilisation of section 115 as a means to record and recognise the preventative work undertaken by AMHPs, and to share and promote good practice. It offers an opportunity to intervene proactively when there is a crisis, but before the patient becomes consumed by that crisis. In conclusion, more discussion and research is necessary to explore the wider role of the AMHP, in particular whether application of section 115 can be incorporated into AMHP practice in conjunction with the care planning and risk assessing practices of CMHTs.

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No potential conflict of interest was reported by the authors.

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Rachael Rooke is a lecturer based at Manchester Metropolitan University, where she teaches across BA, MA and apprenticeship social work programmes. Rachael is a registered social worker and Approved Mental Health Professional. Before working as an academic, Rachael was a full-time Approved Mental Health Professional, and prior to this, a Care-Coordinator on a Community Mental Team. Rachael has over fifteen years' experience in mental health social work practice.