Approved Mental Health Professionals and Mental Health Act Assessments:

A Study of Power, Structures, Communication and (Shared?) Decision-Making

by

Jill Hemmington

A thesis submitted in partial fulfilment for the requirements for the degree of
Doctor of Philosophy at the University of Central Lancashire

March 2023

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Type of Award: PhD

School: Social Work care and Community

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Abstract

Approved Mental Health Professionals (AMHPs) undertake Mental Health Act (MHA) assessments and have overall responsibility for deciding to detain, or indeed to not detain, an individual in hospital without their consent. They are required by law to act autonomously and make independent decisions, free from the influence of others, whilst working in complex and changing systems. Outcomes of MHA assessments are understood to be inconsistent, variable and influenced by many factors and, further, the MHA is known to disproportionately affect some groups or to indirectly discriminate (DoH, 2015b; DHSC, 2018).

Within psychiatry, any focus on power has generally been on the overt, structural or 'macro' aspects of control and coercion rather than the more subtle forms of manipulation at the 'micro', individual level of negotiated decisions. Yet AMHPs are required to embed the statutory guiding principle of 'Empowerment and Involvement' (DoH, 2015a) into their practice whereby service users should be 'fully involved in decisions about care, support and treatment' (para.1.8) and little is known about this in practice.

The forthcoming reforms to the MHA are understood to have the new set of guiding principles on the face of the MHA (not just within guidance) and the new 'Choice and Autonomy' principle speaks of a 'move to mandatory recording of shared decision-making' in order to improve outcomes, acknowledging that culture change is required to ensure that it becomes routine practice (DHSC, 2018 p.36). Yet if MHA assessments are to be a place for shared decision-making (SDM), more needs to be understood about effective techniques and aspects of communication and involvement. This, along with the many variables influencing AMHPs' practice and decision-making has, to date, attracted very little research.

This study was conducted with AMHPs and service users from one Local Authority area in England. A qualitative methodology was employed, within a social constructionist paradigm, to gather in-depth information about AMHPs' experiences and perspectives and to consider the impact of the surrounding imperatives on their practice in general, and on their decision-making more specifically. An ethnographical study was undertaken within an AMHP service where a variety of different AMHP team structures provided an opportunity to consider their respective influences on practice. This was followed by observations and audio-recording of MHA assessments. Conversation Analysis was used to analyse aspects of the content and style of communication within interactions, with particular regard to power relations and the extent to which Empowerment and Involvement and SDM is (or is not) enabled in MHA assessments. AMHPs and people with lived experience were interviewed and a thematic analysis of the data was undertaken. As the study was adversely impacted by the global

COVID pandemic, the research was augmented with a reinterrogation and thematic analysis of findings from a national research project with similar research questions, led by myself, focusing on people with lived experience of MHA assessment and detention (a further under-researched area).

The study addresses both a research gap and a gap between policy aspirations and current practice. Findings offer a refined understanding of the influences on AMHP practice and decision-making and specific ways to enhance involvement with people with lived experience to improve subjective outcomes. This study is original in its combination of qualitative methods using Conversation Analysis to study the *in-situ* dynamics of the MHA assessment process. Different AMHPs both perceive and apply their power and authority in different ways and perceive the empowerment and involvement aspects of the role to be enacted in different ways, leading to an inconsistency in both objective and subjective outcomes.

Key words: Approved Mental Health Professional; AMHP; Mental Health Act; MHA; Mental Health Act Assessment; Empowerment and Involvement; Shared Decision-Making; Conversation Analysis

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Glossary of Abbreviations

AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
CA	Conversation Analysis
CMHT	Community Mental Health Team
DAO	Duly Authorised Officer
EDT	Emergency Duty Team
MCA	Mental Capacity Act
MHA	Mental Health Act
MWO	Mental Welfare Officer
NICE	National Institute for Health and Care Excellence in England and Wales
OD	Open Dialogue
REC	Research Ethics Committee
SDM	Shared Decision-Making
TA	Thematic Analysis
RE	Rapid Ethnography

Chapter One: Introduction to the research: Background and Contexts

Part One: Introduction to the Study

Approved Mental Health Professionals (AMHPs) undertake Mental Health Act (MHA) assessments and they have overall responsibility for deciding to detain, or indeed to not detain, an individual in hospital without their consent. They are required by law to act autonomously and make independent decisions, free from the influence of others, whilst working in complex and changing systems. Decision-making takes place in the absence of guidelines and written 'rules' and there is no established theory or evidence base for AMHP practice. As such, decision-making is informed by aspects of the AMHP's self, their knowledge base and, potentially, other variables. There are different styles of decision-making (Peay, 2003) and variations in AMHPs' professional backgrounds, geographical location, position within different service models and time spent in practice.

Simultaneously, outcomes of MHA assessments are understood to be inconsistent, variable and influenced by many factors (Huxley et al., 2005; Davidson and Campbell, 2010) and disproportionately affect some groups or indirectly discriminate (DoH, 2015b; DHSC, 2018) where people from racialised backgrounds (men in particular) are over ten times more likely to be detained than their White British counterparts (NHS Digital, 2022). Indeed, this was one clear rationale for beginning a reform of the current MHA (DHSC, 2018). Yet, within psychiatry, the focus has often been on the overt, structural or 'macro' methods of power, control and coercion rather than the more subtle forms of manipulation at the individual level of negotiated decisions (Quirk et al., 2012).

AMHPs are required to embed the statutory Guiding Principle of 'Empowerment and Involvement' whereby service users should be 'fully involved in decisions about care, support and treatment' (DoH, 2015a para.1.8) and maximise self-determination (HMSO, 2018) but little is known about how, or if, this happens in practice. Similarly, there is no specific evaluation as to how AMHPs communicate with and relate (or indeed fail to relate) to service users as part of their decision-making about people's liberty.

MHA assessments also take place amidst policy rhetoric and aspirations in mental health settings for the principles of coproduction including the embedding of shared decision-making (SDM) techniques (NICE, 2021). The forthcoming reforms to the MHA speak of a 'move to mandatory recording of shared decision-making' in order to improve outcomes, acknowledging that culture change is required to ensure practice that enables empowerment and involvement becomes routine (DHSC, 2018 p.36; DHSC, 2021). Decisions take place in the communicative space between mental health professionals (specifically AMHPs here) and yet people with lived experience of assessment report being ‘seen but not heard’ (Johansson and Lundmann, 2002). It is what happens within this space that is of interest in this study.

There is little understanding, research or guidance available to explain how to embed the Empowerment and Involvement principle or SDM in practice. More broadly, there is no specific monitoring or evaluation of AMHPs’ practice and decision-making within an assessment context and more needs to be understood about aspects of communication and the ways in which power operates. If MHA assessments are to be a place for SDM, more needs to be understood about effective techniques and aspects of communication and involvement as well as barriers to its successful implementation. This, along with the many variables influencing AMHPs’ practice and decision-making, needs further evaluation to inform debate over potential reform. Finally, there is limited research and understanding of the subjective, lived experience of people who have experienced MHA assessments and detention, and a key part of this study is to begin to address this gap.

A primary focus of this study is the way in which the decision to detain, or to not detain, a person within a MHA assessment is reached. At the micro level this involves an interaction between an AMHP and a service user. Consequently, by way of introduction to this study, Chapter One has been divided into four parts. Part One is a general introduction to the study and its aims and objectives. Part Two introduces the AMHP role and their legal and organisational context. Part Three discusses those with lived experience of MHA assessments and Part Four sets out the background to SDM. Following this I set out the structure of the thesis and define terminology.

Justification, gaps and originality

Despite there being almost forty years' experience and potential for research, there are gaps in research and there is a need for a sharper focus on AMHP practice and decision-making. No specific detail around the process of MHA assessments is available, including in particular the communication and distribution of power therein. This study focuses on this area, as well as offering a new refined and detailed focus on the ways in which practice environments exert an influence on AMHP practice. There is limited research focusing on the AMHP role or how AMHPs arrive at their decisions and what research there is has not privileged the AMHP perspective.

This study begins to address gaps in knowledge around the Empowerment and Involvement guiding principle and on SDM ahead of statutory reforms making this type of service user participation a requirement. One method of data analysis used here, Conversation Analysis, applies a fine-grained examination of talk, enabling a deeper understanding of the operation of power, the epistemics of language, and the ways in which AMHPs facilitate the policy, statutory and values-based imperatives around service users' self-determination and inclusion in assessment scenarios.

Overall, the originality in this study lies in both the focus on empowerment and involvement and SDM within MHA assessments and the application of qualitative methodology incorporating Conversation Analysis with MHA assessments. This observational study is designed to make practice visible not only to outsiders, but also to AMHPs themselves who may take practice knowledge and skills for granted. The knowledge and insight that is generated will have the potential to contribute to policy, practice, research and education – not least by stimulating further critical reflection and self-awareness within AMHP practice.

There is very little research around service users' experiences of MHA assessments as the majority of knowledge relates to experiences in hospital. Conversation Analysis and its fine-grained analysis of interaction have not, to my knowledge, been applied to the study of MHA assessments and the AMHP role specifically. Research to date has not included observation, audio-recording of face-to-face encounters and the use of Conversation Analysis as a method of understanding interactional exchanges and MHA assessments as they actually occur.

Finally, there is yet to be any research or evaluation of the emerging, different modes of delivery for AMHP services and their impact on decision-making, and this study serves as a pilot study in this area.

Study Aims, Objectives and Research Questions

Research Questions:

- What are the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make?

- How could AMHPs facilitate empowerment and involvement and promote shared decision-making in the process of MHA assessments?

Aims and Objectives:

The aim is to undertake a qualitative study to explore how AMHPs in one English Local Authority arrive at their independent decision under the Mental Health Act 1983.

The study's objectives are to:

- Explore the perspectives and interpretations of AMHPs involved in MHA assessments
- Explore how AMHPs understand and experience their role in making decisions in MHA assessments
- Understand the dynamics and power relations between AMHPs and service users in MHA assessments and the extent, from different viewing points, to which the 'Empowerment and Involvement' principle is implemented

Brief overview of the study

This study was conducted with AMHPs and service users from one Local Authority area in England. The methodology is described in detail in Chapter Three. A qualitative methodology was employed, within a social constructionist paradigm, to gather in-depth information about AMHPs' experiences and perspectives and to consider the impact of the surrounding imperatives on their practice in general, and on their decision-making more specifically. An ethnographical study was undertaken within an AMHP service where a variety of different AMHP team structures provided an opportunity to consider their respective influences on practice. This was followed by observations and audio-recording of MHA assessments. Conversation Analysis was used to analyse aspects of the content and style of communication within interactions, with particular regard to power relations and the extent to which Empowerment and Involvement and SDM is (or is not) enabled in MHA assessments. AMHPs and people with lived experience were interviewed and a thematic analysis of the data was undertaken. As the study was adversely impacted by the global COVID pandemic, the research was augmented with a reinterrogation and thematic analysis of findings from a national research project, led by myself, with similar research questions focusing on people with lived experience of MHA assessment and detention. This adds depth and richness to our understanding of service users' experience of MHA assessment, where the focus within existing data is based on service users' experiences of hospital admissions. Including this data enabled a reconciling of AMHPs and service users' views to further inform statutory developments and AMHPs' training around the meaning of empowerment and involvement.

Part Two: AMHPs' contexts and overview of the role

Background to the AMHP: more than a legal role

The AMHP role is an amalgam of legal, professional, administrative and practical functions. It has a lineage from as far back as 1808 in the County Asylums Act. Here, the parish Overseers of the Poor were given the task of identifying those considered to be lunatics, bringing them before the Justices and obtaining a warrant, arranging transport to the asylum and making provision from parish funds for their upkeep. Across statutory and policy developments, the role subsequently became that of the Duly Authorised Officer (DAO), albeit that the role was seen by the Percy Commission as that of a 'mere transporter' or someone who 'prepares documents' including on behalf of relatives (HMSO, 1957). The DAO role was later combined with that of the Mental Welfare Officer (MWO) in the 1950s. Subsequently, this became the immediate predecessor to the AMHP, the Approved Social Worker (ASW) via the 1983 Act (Bean, 1986; Hargreaves, 2000). Significantly, the early iterations of these roles were, to an extent, organisational and political and unconnected to the later development of psychiatry.

AMHPs' independence is fundamental and significant. Debates around this are not new, indeed the issue of independence was discussed in 1955 as part of the Percy Commission review of mental health law, where it was submitted that whilst a responsible MWO would 'not lightly disregard or dissent' from the advice of the doctor, if they are asked to take responsibility for signing an application for detention they 'must in the last resort be free to do so' (HMSO, 1957). The British Medical Association suggested that MWOs' training should be such that they would not want to override the opinion of an experienced psychiatrist. However, in practice, the opposite occurred, and training began to align with the emerging profession of social work.

The reliance on medical discretion in the 1959 Act had been at odds with the growing civil rights emphasis on individual (service user) rights and non-hierarchical work collaboration (Fish, 2022a). AMHPs' independence was further consolidated in the 1975 review of the 1959 MHA where MIND's Legal Officer, Larry Gostin, described psychiatrists' tendency to interpret the Act for their own convenience at the expense of the person's rights. There was a growing concern over the inadequacy of procedural safeguards to prevent unjust deprivations of liberty (HoC, 1982; DHSS, 1978). It was argued that as a deliberate counterbalance to medical opinion the role should be to:

> make an independent evaluation … [focusing on] the person's family and community environment ... and [the professional] should refuse to authorise an admission if there

> are less restrictive community settings in which treatment can be provided. (Gostin, 1975 p.37)

Gostin (1981) also made reference to doctors' medical judgements' 'apparent lack of reliability and validity' which of itself compromised legalistic decision-making (Gostin, 1981). The British Association of Social Workers (BASW, 1977) also submitted that the role must be an:

> independent role which complements the medical opinions … but this must clearly be seen to be from a basis of professional autonomy … the social worker is usually, nowadays, a comparatively junior member of a large, hierarchical department, and the independent status conferred upon him by law is often difficult to sustain in practice. We support the principle of independence, as a valuable safeguard for the patient, and think that it should be more clearly spelt out in the Act (p.16).

The government accepted the case for a parallel 'social assessment' and the ASW role was created within the 1983 MHA. Local Authorities retained responsibility and oversight of the role throughout and, to the present day, healthcare trusts have only limited interests or priorities in relation to the role. The 1983 MHA was amended in 2007 and one of the revisions was to create the role of the AMHP enabling professionals from nursing, occupational therapy and chartered psychology backgrounds to also undertake the role[1].

The AMHP role in practice

With the exception of emergency detentions, or statutory interventions within the criminal justice system, MHA detention decisions involve three professionals:

- an AMHP;
- a doctor approved under section 12(2) of the MHA with specialist knowledge in treating mental disorder (a 'section 12 approved doctor' or s.12 doctor); and
- a doctor who has previous acquaintance with the person where possible or, if a doctor with previous acquaintance cannot be found, a second section 12 approved doctor.

The AMHP's application (the final stage of the detention process) is founded on the two doctors' medical recommendations based on their examination and AMHPs should assess jointly with the doctors where possible (DoH, 2015a para.14.45), although this is often not the case in practice.

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[1] The background and implications of this are reviewed in the following chapter.

The social perspective of the AMHP

The AMHP role was, from its inception, intended to counterbalance the narrow clinical psychiatric model with the hope that a more holistic social perspective and social assessment would enable less restrictive, community-based alternatives to hospital (Gostin, 1975; Walton, 2000). It was an explicit recognition that mental health services and interventions were not the sole jurisdiction of medical professionals, but embedded in social processes that required a more diverse set of skills and understanding that had informally developed among professionals involved in social work (Hatfield et al., 1997). It is 'a social counterweight to the medical viewpoint in the detention' (Bartlett and Sandland, 2014 p.259), a unique social lens, and a role which complements the clinical assessment (SSI, 2004). Decision-making, therefore, goes beyond legal and medical perspectives (Hatfield et al., 1997) and the role is wider than merely responding to crisis requests for admission, making the necessary arrangements and ensuring compliance with the law (LAC (86) 15 para.14). It is understood to involve independent decision-making by professionals who do not have medical training and who are oriented to ensuring legal safeguards for service users that maximise their choices within available community services (BASW, 2003; Fish, 2022b).

It has been asserted that there is little consensus on what the 'social perspective' requires (Fish, 2022a). Broadly, it entails a general commitment to a range of values, a commitment to a holistic approach, an understanding of people in their social contexts, a commitment to hear and take seriously what people say about their mental distress, and an end to 'us and them' thinking (Stone et al., 2020). This lack of a clearly defined set of social criteria is said to sit in contrast to the medical model which, even when criticised, is perceived as being relatively coherent in its methodological application and theoretical framework (Rogers and Pilgrim 2010; Fish, 2022a).

The AMHP's coordinating role

It is the AMHP who has overall responsibility for coordinating the process of assessment (DoH, 2015a 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).

This entails navigating complex inter-agency arrangements (DHSC, 2019) and, in practical terms, includes ensuring the attendance of doctors and other colleagues, including police or ambulance personnel, who may provide transport to hospital.

The AMHP's independence

The AMHP, as the 'applicant', has the ultimate responsibility for making a decision to detain. AMHPs may only make an application for detention if, having interviewed the patient in a suitable manner, they:

> are satisfied that, in all the circumstances of the case, detention in hospital is the most appropriate way of providing the care and medical treatment the patient needs (DoH, 2015a para. 14.49).

As an independent, autonomous statutory role, 'nothing […] shall be construed as authorising or requiring an application to be made by an AMHP' (s.13(5) MHA 1983). The Code of Practice to the MHA (DoH, 2015a) confirms that:

> Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They 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. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principles (para.14.52).

In addition to independence from medical practitioners, then, there is also independence from employers or organisational management structures. Independent from health services by design, AMHPs' duties and powers are intended to be complementary rather than subordinate (Walton, 2000) in order to support the safeguarding of the civil rights of service users.

Organisational aspects of the work are seen by many as problematic. This was not initially the case as ASWs worked for, and within, completely separate organisations. However as mental health services became increasingly integrated[2], with changes to employment contracts, supervision and management arrangements, there developed a perception that doctors would

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[2] Currently, mental health services in many areas of England are undertaking a process of separation and de-integration.

be able to apply ‘undue influence’ and compromise ASWs’ decision-making (Hargreaves, 2000).

Guiding Principles

All those undertaking functions under the MHA have a specific responsibility to follow the overarching guiding principles of the Act, as laid out in its Code of Practice (DoH, 2015a). Whilst it is asserted that it is ‘essential that all those undertaking functions under the Act understand the five sets of overarching principles’ (para 1.1), in practice it is the AMHP who most closely applies these principles. They should always be considered when making decisions in relation to the care, support or treatment provided under the Act (DoH, 2015a para 1.1) and, although of equal importance, the weight given to each principle for each decision to be made will vary. The overarching principles are:

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient’s independence should be encouraged and supported with a focus on promoting recovery.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services.

In keeping with the principle of 'least restrictive option and maximising independence', before it is decided that admission to hospital is necessary the AMHP is required to consider whether there are less restrictive alternatives to detention which 'would include informal admission or support in the community, for example from a crisis team or crisis house' (DoH, 2015a paras 14.7; 14.11). Ultimately, the AMHP's role is to prevent the necessity for compulsory admission to hospital as well as to complete and sign a formal application to detain to hospital where they decide this is appropriate (LAC (86) 15 para.14). This primary goal of preventing admission is, however, frequently thwarted leading to profound emotional and moral difficulties for AMHPs in their practice (Morriss, 2015; Abbott, 2021).

AMHPs' Training

AMHPs must demonstrate competence by completing a course approved by the appropriate regulatory body (Social Work England in England) and they must satisfy the competencies and values set out in Schedule 2 of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 (HMSO, 2008) in order to be approved (or re-approved) to act as an AMHP by a local authority in England. As part of the statutory competencies for practice, AMHPs are also required to:

> promote the rights, dignity and self-determination of persons consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty (1c).

AMHPs must maintain alignment to these competencies throughout their practice in order to be re-approved by the local authority every five years (DHSC, 2019). Allied to the Empowerment and Involvement principle, the professional requirement to maximise a person's self-determination within a MHA assessment is key to this study.

Organisational contexts

The political climate is challenging, with a reduction in mental health resources within both hospitals and the community which have profound impacts on the AMHP role (CQC, 2016). Rates of mental illness in England are understood to be rising, whilst services are not resourced to meet the increased demand. There are insufficient hospital beds and service users are being sent far from home for treatment as a result, with beds for people with a learning disability and mental illness seeing the largest reduction of 56% and 23% respectively since 2010/11, reflecting policies to move care for these groups of people out of hospitals and into the community (BMA, 2022).

There is wide variation in the way that national AMHP services are running; local oversight and data recording is variable. At the time of writing, national bodies are attempting to build a database with a view to monitoring and regulating AMHP services (DHSC, 2019). Recently, however, an area presenting the need for more investigation has been the changing work patterns within which AMHPs work. AMHP services have been undergoing transition and reorganisation leading to an increasingly wide variation in the models of delivery in England (ADASS, 2018; Skills for Care, 2021).

Models include teams dedicated only to MHA work from daytime (with support from Emergency Duty Teams (EDT) outside these hours) through to 24-hour services. Some ‘hub and spoke’ models have part-time, mixed-role AMHPs who support an assessment rota alongside their substantive role. AMHP services can also be supported by sessional or independent AMHPs to be called upon when needed (ADASS, 2018; Skills for Care, 2021).

There are organisational differences in AMHPs’ employment where the majority are employed in the local authority sector (79%), 17% in the NHS and 4% are agency and freelance. Around two thirds (60%) of AMHPs combine their role with another role while around one in four AMHPs (25%) act solely as an AMHP. The remainder are not primarily or regularly working as an AMHP. Only 15% of AMHPs work out-of-hours, for example in EDTs (Skills for Care, 2022). Until now, there has been no research relating to how or if any of these variations influence decision-making or practice more broadly.

The AMHP environment, recruitment and retention

The recruitment and retention of ASWs and AMHPs has been a longstanding problem (MHAC, 1999; Huxley et al., 2005; ADASS, 2018; CQC, 2018; Stevens et al., 2018; NHS Benchmarking and ADASS, 2018, DHSC, 2019). The NHS Benchmarking and ADASS (2018) snapshot survey indicated a 17% drop in AMHP numbers from the previous survey. The latest Skills for Care (2021) survey suggested an overall estimated headcount of approved AMHPs in England to be 3,800 which was a drop in numbers from 2020.

Simultaneously, there are increasing numbers of applications for detentions in England under the MHA (ADASS, 2018; CQC, 2018; NHS Digital, 2021). There is also an increasing number of assessments as, due to the lack of hospital beds and community resources, assessments are delayed, and people are being assessed more than once.

AMHPs consistently work in highly pressurised and stressful environments. Survey reports (CQC, 2016; 2018; BASW, 2016) indicate that stress amongst AMHPs is high, as statutory work becomes 'increasingly squeezed'. AMHPs are under 'extreme pressure' and, of great concern, 'feel forced' to compulsorily detain in the absence of a less restrictive option (BASW, 2016).

AMHP Policy Contexts

The first National Workforce Plan for AMHPs was launched in 2019 (DHSC, 2019) and it considered the 'national drivers' affecting the role. Asserting that AMHPs need to have the 'tools and organisational structure to do the job' (p.20) and that they need to be 'appropriately supported and resourced' (p.20) to do this, it sets out workforce requirements and a structure to consolidate, stabilise and support the AMHP workforce. It established new service standards to be audited as part of an agreed operating model for local authorities. Designed to address the high level of stress and burnout, as well as ongoing recruitment and retention problems in the AMHP workforce, Standard Four of the workforce plan pertains to 'AMHPs' personal, professional, physical and psychological safety' which specifies that AMHP service arrangements should 'ensure that AMHPs' safety and well-being is at the forefront of operational considerations' (4.1). Additionally, AMHP services should support AMHPs' independence in relation to their decision-making and ensure that AMHPs have access to individual, peer and professional support, can explore their working practices in a safe manner and are provided with 'timely de-brief sessions'. Supervision should be viewed as the 'cornerstone of quality AMHP Practice' (4.3).

This national plan begins to consolidate the different aspects of AMHP work and their relative challenges. It recognises that there are influential organisational and environmental contexts, that AMHP work is values-based and oriented to a human rights approach, and it acknowledges the affective and relational issues attached to the work. The plan considers the experiences of people who have experienced AMHP services, and it speaks of the need to promote their dignity, human and civil rights (6.1). It also suggests that AMHP services should promote personalised and preventative care, equality of access to legal entitlements and should aim to reduce stigma, in particular in tackling racial and cultural disparity (6.2). More broadly, AMHP services should seek to embed the principles of coproduction (6.3), to 'ensure the patient experience and perspective is captured and harnessed' and to identify ways in which service users are 'able to engage and influence the development of AMHP services and AMHP practice' (6.3). Social models of mental health should be promoted and reflected in AMHPs' recording and reporting and, finally, AMHP reporting should make clear reference to the principles of the MHA and how the AMHPs have considered these throughout their work with individuals and those connected to them (p.34). Health Education England (HEE, 2019) is overseeing the ongoing development of a national workforce strategy with a plan for AMHP services to be audited against these standards.

Five dimensions of AMHP work

There are several viewing points and domains that influence AMHPs' experience of the work and their decision-making. The work is practical and processual as AMHPs have a role around coordinating MHA assessments and attempting to find alternatives to admission; it is a statutory, legalistic role where AMHPs are seen as having expert knowledge of relevant statute; the professional aspects of the role involve the 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, interpersonal and involves a critical awareness of the use of self in practice. These five dimensions are set out in diagrammatic form, below:

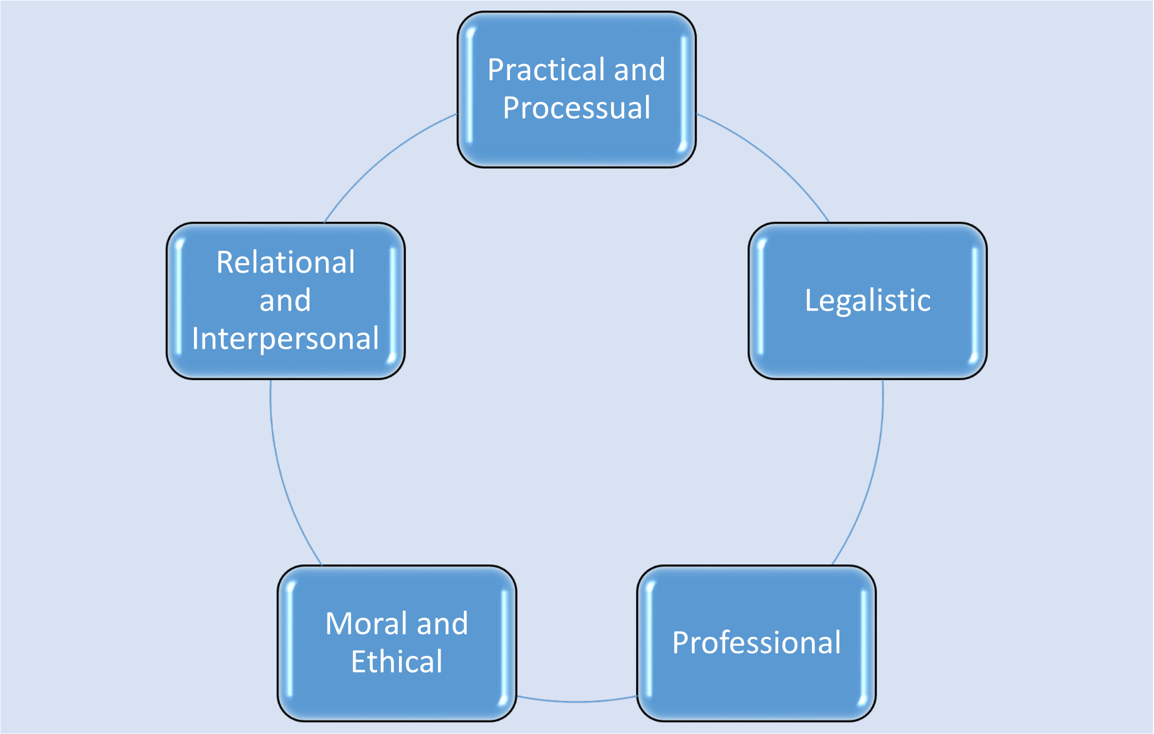

Figure 1 Five Dimensions of AMHP Work

By extension, the influence these dimensions have upon AMHPs' work ultimately impacts the service user in their lived experience of an assessment. Consequently, as decisions arise in the communicative space between service users and AMHPs, the relational and interpersonal aspects of the work become of crucial importance and drive the particular focus of this study upon communication, Empowerment and Involvement and shared decision-making.

Part Three: People with lived experience of MHA assessments and detention

Within research, the voice of people with lived experience of MHA assessments, and thereby ASW or AMHP interventions, has been limited if not 'almost completely lacking' (Akther et al., 2019). More needs to be understood about the process of the MHA assessment (Johansson and Lundman, 2002; Wyder et al., 2013; Matthews et al., 2014; Hall, 2017; McGuinness et al., 2018). There is only a very small body of research exploring service users' experiences of these (Barnes et al., 2000; Hemmington et al., 2021; Blakley, 2021). There is a particular research gap around assessments that do not result in detention (Buckland, 2020). Generally, the literature conflates hospital detention and the assessment process.

Power, or more specifically power imbalance, is an inescapable feature of mental health services. The exercise of power over individuals is legitimated for psychiatry and consolidated in legislation. As a specialty developed originally from outside the rest of medicine (Ramon 1985) psychiatry's history has been one of social control with a heavy reliance on drug treatments (Rogers et al. 1998), justified and codified through statute, albeit expressed within benign motives of 'care'.

The lack of research into the perspectives of those with lived experience of assessment and detention could be said to be indicative of the comparative value assigned to different types of evidence and research priorities (Barnes et al., 2000). Similarly, little is known about the experiences of people from racialised backgrounds who have experienced statutory assessment or detention, which is of particular concern given the greater likelihood of their being detained (Gajwani et al., 2016) or having entered mental health services through the criminal justice system (Bhui et al., 2015; Akther et al., 2019).

In order to highlight the perspectives of people subject to MHA assessment, there follows a summary of the literature relating to people with lived experience of assessments and detention from the following thematic perspectives: power and coercion; relationships with professionals; emotional effects; the inpatient experience; information and involvement; and, finally, ambivalence.

People with lived experience: Power and Coercion

According to Buckland (2020), MHA assessments are inherently threatening and are experienced as being deeply unequal. The threat is such that people adopt a sense of fatalism, becoming resigned to their fate and believe that 'resistance is futile, particularly where the police are involved' (Quirk et al., 2000, p. 45). Assessments have been experienced as intrusive or, worse, as an ambush, a direct threat or as a means of wielding power (Newbigging et al., 2012; Hemmington et al., 2021). People have described being deliberately misled about the encounter being a statutory assessment (albeit as part of trying to help, to reduce distress or to not increase risk) and this damages trust (Anonymous, 2017). Some service users have expressed a fatalistic view that coercive treatment is inevitable, compounding feelings of failure and powerlessness, in that even if they were to appear to agree then it would be as a consequence of a coercive measure (Olofsson and Norberg, 2001). This also mirrors an observed 'fatalistic pessimism' of staff (James, 2013).

MHA assessments often have three or even more professionals involved which is experienced as 'daunting', 'intimidating', 'oppressive', a 'terrible pressure' and, powerfully, a 'barrage of three' (Blakley et al., 2021). Assessments arguably take place within a psychiatric framework where resistance to compulsion and coercion (particularly in violent terms) can be perceived as irrational when it may in fact be understood to have legitimacy (McKeown et al., 2019) in the face of oppressive or perceived confrontational practice. As this study goes on to consider, power resides in interpersonal relationships in that it is constructed through professional practice and communication as well as organisational cultures (Sheldon, 2011). Certainly, issues of structural power affect people's experiences differently, particularly in terms of race, gender and disability (physical and intellectual) (Gould, 2012; Gilburt et al., 2008).

Molodynski et al (2016) defined coercion as 'the action or practice of persuading someone to do something by force or threats' (p.3) although there is no single, uniformly agreed definition in relation to clinical practice (Allison and Fleming, 2019). It has been conceptualised as ranging from harder coercion (including statutory interventions, physical restraint and enforced medication) to softer types (Lidz et al., 1998; Szmukler and Appelbaum, 2008). Within mental health settings, soft coercion represents a *perceived* threat of punishment or force (Gilburt et al., 2010; Lloyd-Evans et al., 2010) which is there in a subtle form, as part of interpersonal interactions wherein one person exerts their will on another and *infers* the potential to action a threat (Lutzen, 1998; Allison and Fleming, 2019). In MHA assessments the potential for loss of liberty is an ever-present 'elephant in the room', inescapably and inevitably influencing the conversational dynamics (Quirk et al., 2003).

Service users have reported a lack of understanding of the difference between informal[3] admission and compulsory detention, where they perceive coercion even where they are admitted to hospital informally (Manktelow et al., 2002). There is concern as to whether 'voluntary' admission could ever be truly voluntary given that, paradoxically, a significant proportion of informal services users can experience the same level of perceived coercion as that experienced by detained patients (O'Donoghue et al., 2014; Perry et al., 2019). Coercion can therefore be both objective (people are subjected to force) and subjective (interventions *feel* coercive). Of significance to this study is that experiences of coercion (including restraint or forced medication) are also not necessarily attributed to the use of statute and detention itself, but to the *relationship* with the staff who are enforcing it (Gilburt et al., 2008). Relationships and communication methods are key.

Yet despite not being the norm within the research literature, positive outcomes are possible, and they represent important knowledge for a study such as this. Although coercive interventions are typically experienced negatively, their impact may also be mitigated by kind and caring staff (Katsakou and Priebe, 2007; Wyder et al., 2015). People who have *not* felt coerced believed they were actively involved in their admission and treatment process, were given information about the reasons, offered alternatives and given time to consider their options and to make decisions accordingly (Katsakou et al., 2011; Akther et al., 2019). Talking to the person may not change the nature of the coercive intervention but it may make them feel respected as a human being (Olofsson and Norberg, 2001; Wirtz et al., 2006; Katsakou and Priebe, 2007; Widdershoven and Van Der Scheer, 2008; Sheehan and Burns, 2011; Wyder et al., 2015; Blakely et al., 2021) – an important outcome of itself. A focus within this study is to seek to understand some of these relational impacts and power dynamics and specifically to consider how they might influence decision-making (and how it is shared or not) or inform aspects of empowerment and involvement – subjectively or in terms of conversational techniques.

People with lived experience: relationships with professionals

Due to the gap in the research literature, little is known about the assessment process. Findings indicate that it can be excluding and patronising but that this can be mitigated by being heard and respected (Blakley et al., 2021). Whilst the AMHP is not involved beyond the assessment and conveying a person to hospital, they are required to consider the

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[3] I deliberately use informal to denote legal status under s.131 of the MHA. The use of 'voluntary' implies choice where, given the circumstances and inherent threats, choice may be perceived to be absent.

circumstances on the wards as part of their decision-making (DoH, 2015a) and have been criticised by service users for not being seen to do this doing this (Hemmington et al., 2021).

The majority of the research with people with lived experience relates to inpatient settings, where psychiatric wards have been described as notoriously unsafe and untherapeutic environments to be in (Spandler and Poursanidou, 2012). The varying experiences and effects on the self, relationships and recovery are, however, linked to the availability or quality of caring and supportive relationships with ward staff and other mental health professionals (Hughes et al., 2009).

Difficult experiences can be mitigated by good interpersonal relationships, good communication and by being listened to, believed and understood (Larkin et al., 2009; Wood and Alsawy, 2016; Akther et al., 2019). Being treated with respect is important (Olofsson and Norberg, 2001; Katsakou and Priebe, 2007; Sheehan and Burns, 2011). Service users prioritise empathy, a focus on the relationship, the emotional aspects of decision making, trust, and the partnership aspect of decision-making (Woltman and Whitley, 2010; Akther et al., 2019). People have expressed the need for a ‘human connection’, to be valued and to be treated like an ‘ordinary’ person (Van DeVeer, 1992; Newbigging et al., 2012; James, 2013; Akther et al., 2019). Trust and empathy appear to be key to a good therapeutic relationship.

Overall, there is a need for trust, mutual respect and an acknowledgment of power differences (Gerace et al., 2018; Akther et al., 2019). Detention has a clear potential to set an antagonistic context for relationships and creates a ‘them and us’ atmosphere particularly on hospital wards (Barnes et al., 2000) and it can also be perceived as having been used as a form of punishment (Andreasson and Skarsater, 2012; Nyttingnes et al., 2016).

Understanding professionals’ attitudes and approaches is crucial and these have been observed to vary between ‘the bulldozer and the ballet dancer’ (Bjorkdahl et al., 2010), providing key messages for this study. Arguably, there is a gap between a rhetoric of therapeutic alliance and the reality of coercive practices. These may also compromise therapeutic relations as a consequence of a sense of alienation on the part of professionals who have become cast in a custodial role which conflicts with more idealised notions of care (Gadsby and McKeown, 2021).

People with lived experience: emotional effects and the impact on the Self

MHA assessments are likely to be in the form of the ‘last resort’ where people have described the assessment experience as a ‘humiliation’ (Quirk et al., 2000) and as being ‘horrific’, with them experiencing anger, dread, trauma and fear (Hemmington et al., 2021) and ‘feeling terrified’ (Seed et al., 2016). They have felt degraded, humiliated, ashamed, embarrassed and thought the experience to be the ‘worst thing that could happen to anyone’ (Blakley et al., 2021).

Disempowering and dehumanising effects of detentions are ubiquitous in the literature. People have described the experience as being infantilising, as being treated as a diagnosis rather than a person, or like a criminal, with long-term damage to self-confidence and self-esteem (Barnes et al., 2000; Sheldon, 2011). Detention is often frightening and distressing (Newbigging et al., 2012) and associated with reduced feelings of self-worth, self-respect and a loss of credibility, dignity and rights (Thompson, 1997; Chambers et al., 2014). The stigma and marginalisation associated with compulsory detention can have a long-term impact, both within mental health services and more generally (Barnes et al., 2000; Manktelow, 2002; Akther et al., 2019). It has been described as tainting a person’s future (Chambers et al., 2014).

Yet where things have been seen to have been manageable or even gone well, the mental health professional has conveyed warmth and reassurance (Gregory and Thompson, 2013), has offered time and has listened (Blakley, 2021) or they have acted as advocate and ‘stood up’ for the person (Hemmington et al., 2021). Hearing, accepting and acknowledging areas that can be addressed can be a strong basis for change.

People with lived experience: information and involvement

Within assessments, service users have reported little discussion around options and alternatives to hospital admission, leaving them to believe that the only outcome could be admission (Barnes et al., 2000; Blakley et al., 2021). People are often left unaware of the nature of the assessment, describing the experience as ‘deliberately secretive … and Kafkaesque’ (Blakley et al., 2021). This is experienced as particularly problematic where mental health professionals literally take the decision-making elsewhere and the person is left worrying and ‘waiting for the verdict’ (Blakley et al., 2021; Hemmington et al., 2021). The assessment has been described as being a *fait accompli*, where people had not been involved and were pessimistic as to their influence, rather than it being a two-way process of decision-making (Blakley et al., 2021) or being offered information or understanding about the legal processes and roles (Marriott et al., 2001).

In terms of hospital admissions, a lack of information and involvement in decision-making has been particularly problematic (Katsakou and Priebe 2006, 2007; Jankovic et al., 2011; McGuinness et al., 2013; Seed et al., 2016; Smyth et al., 2017) and many people do not understand why they are detained (Barnes et al., 2000; Katsakou and Priebe, 2007). Yet, providing information as soon as possible appears to reduce fear, to reduce the impact of coercion, to improve relationships with staff and to result in patients feeling less disempowered (Chambers et al., 2014; Giacco et al., 2018; Akther et al., 2019).

People with lived experience: Ambivalence

Notwithstanding the difficulties associated with assessment and detention, people with lived experience of MHA assessment and detention describe ambivalence. Although compulsory detentions are associated with coercion and trauma, within a month of their being discharged from hospital, between 39% and 71% of patients believed their involuntary admission to have been justified (Priebe et al., 2009)[4]. Compulsory admissions are a 'last and unwelcome resort', but people can often reflect that their admission was necessary (Gardner et al., 1999; O'Donoghue et al., 2009) or that it saved their life (Hemmington et al., 2021). People may experience relief when they have relinquished control and an external containment, in the form of a detention, is applied (Thompson, 1997).

The current study attempts to further explore this complexity, incorporating aspects of choice and ambiguous, complex, and conflictual experiences (Poursanidou, 2013). Spandler and Poursanidou (2019) point to the unhelpful binary oppositions in mental health settings (physical/mental; social/medical; psychiatry/anti-psychiatry; etc.) and suggest that these differences and diversity of perspectives needs to be acknowledged. Certainly, adopting one perspective has consequences: an exclusively anti-medical, anti-psychiatry or abolitionist position (e.g. Róisín, 2022) excludes people who choose psychiatric support, medication, or medical intervention (Golightley, 2016). This is particularly key in terms of my own position which, as will be seen, incorporates academic, practitioner and organisational ones.

Deliberately adopting an ambivalent, non-binary approach acknowledges that people's circumstances are context dependent (Callard, 2014). An aim of this study is to explore in

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[4] The wide span here, summarised from a review of available literature, is due to studies having inconsistent methods or research aims in a variety of contexts. There are very few, if any, validated instruments to assess people's attitudes as to the justification of their (involuntary) admission and treatment, or their perception as to benefits from it (Priebe et al., 2009; Katsakou and Priebe, 2006).

broad terms how this is manifested and to consider ways in which to contribute to a more relational or consensual mental health system. Caton and Kilyon (forthcoming, 2023) described their striving to campaign for changes to the mental health system to incorporate healing, respectful and non-compulsive ways of working. They acknowledge a potential for hospital admissions to be a less distressing environment and therefore environments that people might choose to be in – which of itself might influence rates of compulsion. Choice, autonomy, agency and sharing ‘treatment’ decisions are a key themes within this study.

Part Four Shared Decision-Making

The idea that people should be offered more choice within healthcare settings has been increasingly developed, with Costa-Font and Zigante (2016) viewing the expansion of the 'choice agenda' as 'a dominant reform' (p.409). This has been associated with suggestions that versions of SDM are an ideal approach (Edwards and Elwyn, 2009). The NHS Choice Framework (DHSC, 2016) and the Department of Health's (2007) *Choice Matters* discuss the notion of 'choice' and broader aspirations such as 'patient empowerment' as one (Toerien et al., 2018).

SDM is enshrined as a principle in England's National Health Service Constitution, with Principle Four stating that 'Patients … will be involved in and consulted on all decisions about their care and treatment' (DHSC, 2021). The General Medical Council's (2020) guidance on decision-making and consent says that 'shared decision making and consent are fundamental to good medical practice' (p.1).

In mental health settings, there are policy trends and organisational rhetoric referring to collaboration, coproduction and SDM with people who use (or are subject to) mental health services. For example, NICE guidelines for psychosis include 'working in partnership' with service users (NICE, 2014 p.10; NICE, 2021). Yet there is evidence that SDM (and how to enact it) is poorly understood or absent in mental health settings despite it being congruent with a broader aspiration toward, or commitment to, principles of coproduction.

The Empowerment and Involvement Principle

Within this study, SDM is seen as being closely related to the Empowerment and Involvement principle as outlined above. A core aim of this study is to understand how AMHPs' apply and enact this principle. Given its importance here, it is briefly outlined, below:

Empowerment and Involvement

Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient (para.1.7).

A patient's views, past and present wishes and feelings … should be considered so far as they are reasonably ascertainable (para.1.8)

The patient's choices and views should be fully recorded. Where a decision … is contrary to the wishes of the patient or others the reasons for this should be transparent, explained to them and fully documented (para. 1.9)

Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them (para. 1.10)

DoH (2015a).

There is no research or practice guidance as to how this principle is understood and applied.

Similarly, part of the qualifying criteria and ongoing practice imperatives for AMHPs in England and Wales rests on the professional's ability to:

> promote the rights, dignity and self-determination of persons consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty (1c) (HMSO, 2008).

This too is interrelated but is also under-researched and lacking evidence as to how it is enacted.

Shared Decision Making: Background and Overview

The benefits of versions of SDM have been argued from different perspectives. For example, ethicists argue that it is a self-evident right that people should determine what happens to their bodies (Nelson et al., 2001). Economic perspectives see increased consumer control as a means of embedding the healthcare industry further within forms of market discipline (Polsky et al., 2003). Clinicians believe that including people in decision-making leads to an enhanced therapeutic relationship and health outcomes including treatment 'adherence', treatment satisfaction, and improved biomedical outcomes (Adams and Drake 2006; Drake et al., 2010; Morant et al., 2016). Politically, SDM is allied with the growth in agendas such as personalisation, choice and competition in service delivery SDM and as such it also reflects a broader policy orientation towards the neo-liberalisation of health and social care (Glasby, 2012). These points are returned to later in this study.

As indicated earlier, offering service users more control has been part of policy rhetoric and recovery-oriented practice position for some time (Woltmann and Whitley, 2010; Morant et al., 2016). SDM is promoted in government policies and practice guidance, including NICE guidelines where it is described as an empowering process enabling people to understand the risks, benefits and possible consequences of different options, including choosing to have no treatment or to not change treatment they are currently receiving. It means:

> communicating with people in a way they can understand, using clear language, avoiding jargon and explaining technical terms and making sure [people] understand the choices available to them (NICE, 2021 p.1).

Whilst SDM is a relatively well-developed practice within non-mental health settings, a significant rationale for its focus in this study is that it is far less likely to be accepted and practiced in mental health settings where it is seen to lag behind the broader medical field in embracing a vision of partnership (Adams et al., 2007; Drake et al., 2010; Matthias et al., 2013; Morant et al., 2016). More needs to be understood about the ways in which decisions are made by mental health professionals and whether these decisions are made through a shared process or include factors facilitating or impeding participation (Matthias et al., 2013; Eliacin et al., 2015).

As SDM rests on a person-centred approach more needs to be understood about service users' perspectives around the way decisions are made (Eliacin et al., 2015). Adams et al (2007) found that within mental health settings, service users' wishes to participate are not explicitly assessed, that professionals are not trained or informed around adopting SDM approaches, they have not developed the tools to facilitate SDM and they have not measured the effects of SDM. These findings are a significant driver in the focus on SDM in this study.

Most theoretical and empirical work regarding decision-making in mental health settings suggests that service users have better outcomes when their preferences are integrated into decision-making and that many mental health service users do wish to be involved in decisions regarding their own care and desire collaborative working relationships (Adams et al., 2007).

However, despite the desire for involvement, evidence suggests that mental health professionals and service users understand concepts of autonomy and 'decision sharing' differently, that professionals have difficulties predicting what service users' priorities are and that professionals' preferences tend to dominate, with decisions often being made without any negotiation at all (Woltmann and Whitley, 2010; Sandman and Munthe, 2010).

Professionals often use inaccessible technical language and service users report being 'seen but not heard' (Johansson and Lundmann, 2002). Interestingly, clinicians may not automatically enable participation but, instead, intuitively 'feel' if a person wants to be involved or not (Goossensen et al., 2007). Further, issues around capacity within mental health settings exacerbate barriers to SDM where a lack of cognitive capacity has been seen to affect a person's 'insight' and communication. Service users value empathy and the relational, affective, emotional, trust and partnership aspects of decision-making more highly than information-gathering (Britten, 1998; Rogers et al., 1998; Woltmann and Whitley, 2010). This relational aspect has yet to be fully explored within the context of AMHP decision-making.

Shared Decision-Making: Approaches, Definitions and Models

Shared decision making is defined as:

> a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future … It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values … It means making sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing. This joint process empowers people to make decisions about the care that is right for them at that time (with the options of choosing to have no treatment or not changing what they are currently doing always included). (NICE, 2021)

NICE (2021) recommend that training and development should aim to provide an understanding of the principles that support SDM including evidence-based models. SDM means encouraging people to talk about what is important to them and communicating in a way that they can understand, using clear language, avoiding jargon and explaining technical terms and making sure they understand the choices available to them (including the choice of doing nothing). Evidence-based models include, for example, the Teach Back method which is to seek confirmation that the information provided is being understood by getting people to 'teach back' what has been discussed. This is more than saying 'do you understand?'

There is no agreed definition of SDM (Makoul and Clayman, 2006; Muller-Engelmann et al., 2011; Eliacin et al., 2015) and some have questioned whether we are ‘all talking about the same thing’ (Moumjid, 2007). The earliest mention of it was in 1982 (Elywn et al., 2012), when it could be seen to emerge from the principles of person-centred approaches (Lloyd et al., 2012) and there was a developing interest in the skills required for this (Elwyn et al., 2012). Within the literature, the most commonly cited SDM framework is that of Charles et al (1997) where SDM is understood to be an interactive process between at least two parties (service user and provider) who participate in all stages of the decision-making process. In this framework, providers and service users work collaboratively to set goals, explore health concerns and treatment preferences, discuss treatment options and, ultimately, decide together on a course of action. The emphasis is on systematic, interactive participation from both person and professional in the decision-making process and agreement on the decision. Using formal stages, both person and professional share information and opinion and bring preferences and responsibilities which they discuss and deliberate upon in order to reach a joint decision over a course of action. In the absence of initial agreement ‘a process of negotiation is likely to occur’ (Charles et al., 1997 p. 656). It is a process by which professional and service user engage in a two-way exchange of information and knowledge (formal and experiential), to clarify values and influences regarding a treatment decision and together to agree on a plan of action (Charles et al., 1999; Matthias et al., 2013).

Professionals bring their understanding of the problem (albeit from an apparently predominantly clinical perspective), the possible interventions and the potential benefits and risks of these alternatives. The service users (potentially assisted by family or supportive network members) bring expertise related to their personal experience, values, goals and preferences. The ‘partners’ represent their respective views and then negotiate a plan that they agree is ethical, consistent with the evidence, congruent with individual preferences and practical (Drake et al., 2022).

It appears that a robust, trusting person-provider relationship is integral to SDM and key relational characteristics include equality and partnership, mutual agreement, trust and honesty, and care and empathy (Eliacin et al., 2015). This is a dimension to SDM that Charles et al did not discuss: the professional-service user relationship as not only simply a prerequisite for SDM, but a necessary component that frames the context in which SDM occurs (Eliacin et al., 2015). This, as will be seen in later chapters, is a primary concern in MHA assessment.

Developing an interactional approach involves two main strategies: improving communication and providing people with decision aids. Communication interventions for professionals can address verbal and nonverbal skills to enhance affiliation and the therapeutic alliance (Horvath and Symonds, 1991) and to elicit and respond to service users' concerns (Joos et al., 1996). These are, however, relatively under-researched areas (Adams and Drake, 2006).

Models of SDM vary in the way they position the roles and responsibilities of each party. For example, Towle and Godolphin (1999) suggested that there are competencies required for both professional and person, whereas others have placed more responsibility on the professional to elicit or respond to people's views (Edwards et al., 2003). Positions vary in terms of each party's involvement in decision-making and decisional control but two common strategies to promote SDM are, firstly, communication training for clients and clinicians and, secondly, decision aids or information technologies/support programmes to provide targeted information and values clarification (Drake et al., 2010).

Shared Decision-Making: Values and Power Sharing

A core position of SDM is that all parties have important contributions to make: professionals have current and accurate information regarding diagnosis, course of illness, moderating factors, treatment options, side effects and so on, and service users, on the other hand, are the experts on their own values, treatment preferences and treatment goals (Charles et al., 1997). The collaborative process is based on mutual respect, open communication and consideration of individual preferences and values (Morant et al., 2016).

Fundamentally, SDM approaches accept that individual self-determination is a desirable goal and that the professional's imperative is to support service users to achieve this goal wherever feasible. Key tenets of self-determination and relational autonomy (Makoul and Clayman, 2006) apply. As outlined above, AMHPs have a professional imperative to maximise self-determination, an approach resting on a theoretical concern with our intrinsic tendencies to protect and preserve our well-being (Adams and Drake, 2006). 'Relational autonomy' asserts that we are not entirely free, self-governing agents but that our decisions will always relate to interpersonal relationships and mutual dependencies (Elwyn et al., 2012).

Sandman and Munthe (2010) identified three broad models of decision making: paternalism, SDM and informed choice (Joosten et al., 2011). Conceptually, SDM emphasises interaction (Drake et al., 2009) and is a middle-ground approach as it falls between two extremes of medical decision making: the paternalistic and the autonomous decision models (informed choice). In the traditional paternalistic model, the professional assesses what is best, based on clinical judgment, and makes the decision. In the autonomous (or informed) decision-making model, the service user receives (or collects) information from the professional, weighs the information and makes the choice unilaterally (Drake et al., 2010; Muller-Engelmann et al., 2011). Despite this delineation of three models, however, it appears hard to distinguish between them in practice, particularly between SDM and informed choice.

One explanation for this may be that the three models are not entirely separate entities but, rather, are part of a spectrum from paternalism through SDM to informed choice. Where an individual discussion sits on this continuum is a subjective view (Edwards et al., 2003). This continuum also represents the involvement of parties from very passive to very active positions. At one end, service users may prefer a dominant role in which they make the decision and the professional just provides the information on risks and benefits. There is a recognition that not all services users even want an active or even participatory role[5]. Further, some may seek medical attention more for relief from anxiety than for relief from symptoms and this would explain strong preferences for a passive and trusting relationship among service users with emotionally overwhelming illnesses. They may choose to abrogate control and give responsibility for the decision to the practitioner (Edwards and Elwyn, 2001; Adams et al., 2007; Woltmann and Whitley, 2010). Further still, choice in MHA assessments is problematic not least due to aspects of capacity and psychiatric ethics – a discussion returned to in Chapter Three of this study.

In mental health settings it is unlikely that decision-making will be shared equally (Makoul and Clayman, 2006). It is also possible that those who have prolonged experience of the system will have acquired an expectation that they should assume a passive role in decisions (Adams et al., 2007), particularly given the power asymmetries. The balance of medical knowledge and social power in the provider-person relationship is nearly always tipped toward doctors who often take a leadership role with respect to decisions in medical encounters (Makoul and Clayman, 2006). Yet, engaging in SDM does not require that professionals relinquish decision-making authority (Coulter et al., 2017) since SDM can occur even if service users ask professionals to take decision-making responsibility, provided that the essential elements are present (Makoul and Clayman, 2006). As will be discussed in Chapter Six there are arguably more subtle ways in which service users can be enabled to 'share the floor' in discussions and decision-making.

Some mental health service users exhibit autonomous decision making by rejecting their diagnosis or mental 'illness' and refusing to have anything to do with mental health

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[5] I also recognise that the terms 'service user' (a term allied to consumerism) is incongruous in this aspect, and more broadly within a context of compulsion – see note on terminology, below.

professionals[6]. As the SDM model is based on negotiation and encouraging participation it may provide an avenue to participation for such people, even if the negotiation is to accept negotiations in the first place. The pros and cons of a decision can often be framed to avoid the barrier of illness stigma or other prejudices that might be preventing the person being involved (Adams and Drake, 2006). A significant purpose of this current research project is to explore strategies that might make the encounter less of a threat, or to explore objections to communication and attempts at SDM.

Shared Decision-Making: Challenges to its development in mental health settings

Research on SDM in mental health parallels much of the work in general medicine with good communication skills of the practitioner being associated with higher service user satisfaction, greater treatment acceptance and improved outcomes in mental health (Cruz and Pincus, 2002). Crucially, it appears to be the case that the individual characteristics of the practitioner are also related to outcomes (Crits-Cristoph et al., 1991).

Therapeutic relationships and the relational work therein do need to further evaluated, however, as decisions have been observed to be directed and pressured through subtle forms of persuasion and leverage (Szmukler and Applebaum, 2001). Seale et al (2005) observed moments of ‘strategic dishonesty’ within communicative work of psychiatrists, as well as psychiatrists’ own descriptions of obstacles to ‘concordance’ being founded on adverse judgements of patients’ competence and honesty. (Seale et al., 2006) suggest that psychiatrists maintain a self-image of being committed to SDM while some patients simultaneously experience a non-democratic, potentially coercive treatment regime.

Quirk et al., (2012) suggested that some ‘shared’ decisions between psychiatrists and service users are considerably more pressured than others. Here, psychiatrists’ ‘pressured decisions’ are ‘on the margins of coercion’ as service users’ resistance is disregarded and, rather, they are pressurised into agreeing to an outcome they evidently did not want. Less pressured are ‘directed decisions’ or ‘steering the patient’ where the talk is designed, and decision-making is directed, such that the service user chooses what the consultant has marked as the best option. This is a more subtle form of control and the doctor works to cement this decision through techniques such as reassurance. Similarly, ‘letting the patient have it the doctor’s way’[7] is a form of steering the service user to make a choice from options already devised by

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[6] Again, this group may be reasonably be referred to as ‘service refusers’.

[7] Quirk et al (2012) adapt this from the Daniele Vare quotation (n.d.): ‘Diplomacy is the art of letting someone have your way’ (p.113)

the doctor. These forms of ‘persuasion’ were not viewed by service users as forms of pressure or manipulation.

Overall, many mental health service users remain disempowered, believe they are not included in decisions (or that decisions are not made in their interests) and they experience stigma. Meaningful discussions can be compromised by practitioners’ assumptions about ‘insight’ – an assumption which can exaggerate inequalities between service users’ experiential knowledge and the scientific knowledge base of practitioners (Adams et al., 2007; Morant et al., 2016)[8]. Some professionals express doubts about SDM, believing that service users don’t want to be involved in decisions, lack the capacity or ability to be involved, might make bad decisions, or believe that SDM is not practical given time constraints, whilst others claim that they are already doing it, although data from service user experience surveys indicates that this is not generally the case (Adams and Drake, 2006). Overall, however, it seems important to not over-emphasise the final treatment decision but, rather, to direct attention away from the moment a decision is made to focus on the process, the communication (and its barriers) leading up to the decision point and the professional relationship (Matthias et at al, 2013; Eliacin et al., 2015) – a specific focus of the current study.

Structure of this thesis

This thesis is ordered as follows. Chapter Two establishes the contexts for AMHP practice through a detailed narrative literature review, with explicit themes informing the significant aspects of the current study. Chapter Three provides an overview of the methodology and research design outlining the qualitative methodology and social constructionist paradigm used to explore AMHPs’ experiences and perspectives, the content and style of communication within MHA assessments, and service users’ experiences of MHA assessments. Chapter Four provides an overview of the research design and methods. Chapters Five, Six and Seven outline data analysis and findings across the ethnography, MHA assessment and interview phases of the study respectively. Finally, Chapter Eight offers a summary discussion and considers implications for practice, training and further research.

A note on terminology and language

The term ‘mental health problem’ is used as a generic term throughout this thesis, as this is generally in keeping with AMHPs’ social perspectives and is an alternative to automatically

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[8] The concept of ‘insight’ is further critically evaluated in Chapter Three.

conceptualising mental distress as an illness. However, there is a recognition that the term 'mental disorder' is used in statute, so where the context is a legalistic one this will be used.

I also use the terms 'service user', 'person', or 'person with lived experience' interchangeably throughout. I also try to provide clarity as to lived experience of what, exactly, rather than use it as a non-specific term. Where possible I use 'person', acknowledging personhood, but recognise the potential for confusion where specific identities are relevant. I also recognise that 'service user' is not always a preference of people with lived experience of services, not least as it can imply a consumer model of choice (as does 'client') which, in the current context where people are subject to MHA assessments may be incongruent. More recently, 'service receiver' has been adopted, but this does not resolve the challenges around a person's choice (or otherwise). Importantly, given the nature of this research study and thesis I acknowledge the notion of service refuser (Cheng et al, 2008; Blanchette et al., 2019; Spandler and McKeown, 2017) and whilst I do not adopt this routinely (not least as people within this study have not been given the option to refuse) I hope that this acknowledgement will remain implicit in the background.

Whilst no term is ideal, 'service user' is the most commonly used term in mental health settings. It has been argued that it confers a more active role for the person (Morant et al., 2016) (notwithstanding people's reluctance to be involved, as with 'service refuser', above). I may also use other terms (for example 'survivor') to be consistent with the original context, usage or expression of identity but I actively avoid 'patient', unless it is to connote inpatient status or unless it is a direct quote from statute or associated policy. Unless the context is specific (e.g. to the AMHP or doctor), to maintain consistency I use the term 'mental health professional' as a generic representative of mental health services. Finally, I avoid using the lay term 'sectioned' due to its stigmatising connotations. Rather, I use 'detained' to denote a legal status.

Summary and concluding points

AMHPs undertake MHA assessments and they have overall responsibility for deciding to detain, or not to detain, an individual in hospital without their consent. They are required by law to act autonomously and to make independent decisions whilst working in complex and changing systems. AMHPs' decision-making rests on statutory imperatives and broader principles of empowerment and involvement (where service users should be fully involved in decisions about their care and treatment) and the maximisation of service users' self-determination.

AMHP services are undergoing major transition and reorganisation and there is wide variation in the way that national AMHP services are running. There are changing work patterns and models of delivery (ADASS, 2018; Skills for Care, 2021). This research has been designed to explore the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make. An emerging and unexplored area of interest are AMHPs' environmental and organisational influences and these need to be explored further to examine their implications for practice.

These service reorganisations may be understood to be in response to ongoing recruitment and retention difficulties (Stevens et al, 2018; CQC, 2018). The broader political climate is challenging, with a reduction in mental health resources within both hospitals and the community which profoundly impact the AMHP role (CQC, 2016). There are insufficient hospital beds, leading to a preponderance of out-of-area beds (BMA, 2022), and the numbers of assessments rise as people are assessed more than once due to the wait for beds. The AMHP role, on paper, has stayed the same: AMHPs are required to bring a social perspective to bear and to consider whether there are less restrictive alternatives to hospital. A study considering how this affects AMHPs and their practice is therefore timely.

MHA assessments also take place amidst policy rhetoric and aspirations of coproduction and SDM. The statutory and professional principles of Empowerment and Involvement are synonymous with those of SDM. SDM has been understood to be a verb which constitutes a process, supported by specific, deliberate approaches that re-engineer how professionals and service users work together (Drake et al., 2010). This study has therefore been designed to begin to notice and evaluate the dynamics and power relations between AMHPs and service users in MHA assessments. Understanding this is important, not least as outcomes of MHA assessments are understood to be inconsistent and influenced by many factors.

SDM in mental health settings is not well researched and is usually limited to those who are understood to have capacity to make decisions, usually in relation to medication and side effects. Professionals are also understood to lack familiarity and training with some SDM concepts, may even disagree with the concept itself, and often have concerns regarding decisional capacity and legal responsibility (Drake et al., 2010). However, given the clear policy contexts, as well as the impending statutory reforms, more will need to be accomplished in MHA assessment scenarios. This study goes on to explore what happens in a MHA assessment and how communicative actions and conversational manoeuvres influence decision-sharing and power-sharing. This is because more needs to be understood about the facilitation of SDM, including the professional attitudes, values and communication skills needed for it to happen (Cruz and Pincus, 2002). It means looking at how sharing and empowerment are enacted (or blocked) in the moment in order to explore AMHPs' future training and practice.

Service users describe feelings of ambivalence around the necessity of detention. They also describe a fundamental lack of choice. For service users, MHA assessments can be understood to be damaging on personal and emotional levels and in terms of consequences and relationships (Buckland, 2020), but there are ways in which this damage can be mitigated. This study seeks to understand service users' positions and status in the moment of a MHA assessment, and their recollections about their experiences thereafter, in order to gather evidence to develop future training and practice methods. This, of course, is all within a context of the relationships between service users and AMHPs. That relationship is a key part of the study.

Overall, AMHP practice was introduced as having different dimensions: practical and processual; statutory and legalistic; professional (including social perspectives and anti-oppressive practices); moral and ethical (pertaining to AMHPs' independence and state paternalism function); and relational and interpersonal. This study privileges the AMHP's viewing point, it considers the ways in which AMHPs reconcile these perspectives within their practice and it explores the ways in which practice goes beyond a simple legalistic encounter.

The study is concerned with AMHPs' understanding and experiences of their role. It now turns to a narrative literature review to set out what is known about ASW and AMHP work.

Chapter 2: Review of the Literature

A literature review is an objective, thorough summary and critical analysis of the relevant available research and non-research literature on the topic being studied (Hart, 1998; Bourhis, 2017). The goal is to bring the reader up to date with current literature on a topic and to form the basis for another goal such as the justification for future research in the area (Cronin et al., 2008).

One of the aims of this study is to understand the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make. Objectives are to explore the perspectives and interpretations of AMHPs involved in MHA assessments, to explore how AMHPs understand and experience their role in making decisions in MHA assessments and to understand the dynamics and power relations between AMHPs and service users in MHA assessments. However, there has been little specific research into the ASW or AMHP roles, or into the working of the 1983 Act as a whole. Existing research has not prioritised the perspectives of ASWs and AMHPs and there is minimal analysis on the role played by AMHPs as part of the process of detention (Matthews et al., 2014; Hall, 2017). MHA assessments are poorly understood due to the paucity of research in the area (Sheppard, 1990; Campbell, 2010) and research, particularly with people with lived experience, has focused on experiences of hospital detention (Akther et al., 2019) when, generally, the AMHP is no longer involved.

Narrative Literature Review

I chose to use a narrative review (also known as traditional or non-systematic reviews) (Ferrari, 2015; Gregory and Denniss, 2018) as these are aligned with the philosophies and methods of qualitative research (Pawson, 2002). Narrative reviews offer a qualitative summary of the relevant studies and existing knowledge. Using a topical approach, they gather together the volume of literature in a specific subject area, then summarise and synthesise it to provide a comprehensive background. Whilst narrative reviews do not necessarily attempt to locate all relevant literature and may focus the search on pivotal papers, given the limited research in my chosen area I was able to review all that is available and to use this to further refine my own research questions and methods.

Narrative reviews examine the relevant literature for patterns, trends, gaps and inconsistencies and draw general conclusions about the subject area (Coughlan et al., 2007; Cronin et al 2008; Gregory and Denniss, 2018). They can provide a history and trace the development of the topic so that a general narrative is created (Bourhis, 2017). They can set the stage for understanding where a particular body of research began, is currently, and where it should go in the future (Rozas and Klein, 2010). There is no consensus on the standard structure of a narrative review and it may be organised chronologically or presented as a 'conceptual frame', where the contents are separated accordingly (Green et al., 2006; Ferrari, 2015). This narrative summary integrates qualitative and quantitative evidence through narrative juxtaposition (Dixon-Woods et al., 2005). The literature is presented thematically here, attempting to preserve the messages of the original studies.

Basic requirements for conducting narrative reviews include a conceptual structuring of the topic and clear and transparent criteria for selecting relevant studies for review (Cooper and Hedges, 1994; Arksey and O'Malley, 2005; Torraco, 2005). A general type of literature review is more inclusive than, for example, theoretical or methodological literature reviews and this is better suited to my subject area where research is relatively under-developed. I incorporated an element of historical literature review (which examines research throughout a period of time), often starting with the first time an issue, concept, theory, phenomena emerged in the literature and identifying the likely directions for future research (Onwuegbuzie and Frels, 2016). I was looking at material from 1980 onwards to align with the introduction of the distinct statutory roles[9].

A narrative review describes and appraises published work, but the methods used to select these may not be described. As 'unsystematic' reviews, they can include quantitative, qualitative, and mixed-method research, while maintaining validity and rigour (Rozas and Klein (2010) and are therefore understood to have more flexibility and to include insights from the findings of qualitative research (Bourhis, 2017) making their reach broader and more inclusive (Rozas and Klein, 2010). No methodological approach is privileged and no evidence is excluded on the grounds of methodology (Dixon-Woods et al., 2005).

A meta-analysis could be seen as the architectural structure: its frame defines a particular area of research but it lacks rich description. Qualitative research may emphasise the context as the matter that fills the frame to complete the structure (Barbour, 2001). This 'interior architecture' (Rozas and Klein, 2010) represents a 'ground-level view' of what happens (Pawson, 2002). Ultimately, it is this ground-level, micro view that I seek to understand further. An inclusive narrative review is therefore essential if I am to trace the development of significant principles and concepts. I did not want to risk the narrative thread becoming lost

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[9] This refers to the Mental Health Act 1983 but I wanted to check for any anticipatory or statutory review papers.

under restrictive rules of a systematic review (Ferrari, 2015) and the body of relevant material does not lend itself to a rigorous systematic review. The variation in types of ASW and AMHP research (much of which is very small-scale) and literature certainly indicates the wider scoping of a narrative review.

Difficulties for narrative analyses are found in balancing simplicity and succinctness with the need to include nuance, details and generalisations (Bourhis, 2017). Additionally, a narrative review is not reproducible (Ferrari, 2015) although this may also be considered a strength in the way that it relates to research questions in the moment. On the other hand, this last point raises the risk of the impact of the reviewer's bias (Oxman and Guyatt, 1988; Slavin, 1995) as all narratives represent only one possible telling of the tale or organisation of the available information (Green et al., 2001). Subjectivity in study selection is the main weakness ascribed to narrative reviews that potentially leads to biases (Yuan and Hunt, 2009; Ferrari, 2015) and, whilst I was able to avoid selection bias as the body of literature is small enough to achieve completeness through electronic and manual searches, I acknowledge that there will always be an inherent evaluation bias.

Literature Search

In order to gain a full understanding of the research and literature to inform this study in breadth and depth, an EBSCO host database search was undertaken using Boolean operators. The following electronic databases were searched:

Academic Search Premier, Applied Social Science Index and Abstracts, CINHAL (EBSCO), MEDLINE (OVID), PSYCH info, Royal College of Nursing, SCOPUS, Social Care online (SCIE), ScienceDirect (Elsevier), Social Services Abstracts

Date ranges were entered from 1980 onwards as this was consistent with the statutory framework (the 1983 Mental Health Act introduced the Approved Social Worker). I aimed for well-defined key words and search terms to retain a focus and to ensure the review would be feasible (Gregory and Denniss, 2018). Search terms, based on research questions and aims, were:

Approved Mental Health Professional
Approved Mental Health Professional AND Mental Health Act
Approved Mental Health Professional AND mental health
Approved Social Worker
Approved Social Worker AND Mental Health Act
Approved Social Worker AND mental health
ASW* AND AMHP*AND Approved* AND Mental health* AND Social work*

Approved mental health pr* was used for completion and to search for any discrepancies (particularly around the 1983 MHA revisions where Approved Mental Health *Practitioner* has been used erroneously).

Reference chaining, by means of manual hand-searching of all articles selected, revealed additional references and citations that had not appeared in the electronic search. This included books, book chapters and relevant reports for which there were many citations. This revealed one or two ‘sleeping beauties’ or older publications, that would have gone unnoticed (Van Raan, 2004).

Exclusions were:

- Returns pertaining to jurisdictions with significantly different mental health statute and no role comparable to that of the AMHP or ASW. This did not include Northern Ireland and Wales, which were accepted due to the similarity and overlap in roles
- Returns not written in UK English, again to maintain consistency with the relevant legal jurisdictions

As I already work within a relevant practice and education field, I was able to use networks, contacts, colleagues, organisations and conferences to learn about current or imminent primary research or other publications. This included the national AMHP Leads Network and contacts within DHSC and Skills for Care as well as other academic colleagues.

Finally, I searched grey literature including:

British Association of Social Workers (BASW) website
Centre for Mental Health
Department of Health
EthOS
Health and Care Professions Council
Mental Health Act Commission
Mental Health in Higher Education
Social Care Institute for Excellence (SCIE)
Social Work England

Following these stages, the searches had produced a manageable (below one hundred) number of returns for in-depth reviewing and did not need to be narrowed. I was satisfied that the search had met the search criteria and was and inclusive, although it was repeated periodically to date to ensure currency.

The next stage was ‘charting' key items of information obtained from the primary research reports being reviewed (Ritchie et al., 1994). This involves interpreting and synthesising data by sifting, charting and sorting material according to key issues and themes and making detailed notes on each one. I found that a table of information made it easier to organize my thoughts when constructing the synthesis and to categorize information by topic (Green et al., 2001). To find a logical structure, the material was recorded thematically (as opposed to chronologically or by methods) (Gregory and Denniss, 2018) and this is consistent with a narrative review approach (Pawson, 2002). The outcomes of the literature were organised thematically, but several key publications overlapped many theme types and have, accordingly, been cited several times. This proved to be a detailed and time-consuming activity since there was significant overlap among reports.

A combination of the number of times a particular theme arose was allied to subjective judgements about the relative significance of the particular themes. The final literature review has been organised around these categories. Developing this framework for collating and summarizing results required me to prioritise certain aspects of the literature around my own research questions. I aimed to ensure that my themes incorporated the theoretical or conceptual positions held by the original authors (Arksey and O'Malley, 2005). At the same time, I did not want to simply summarise the literature, as it is ‘not stamp collecting’ (Pautasso, 2013 p.2), so I also aimed for criticality in terms of gaps, similarities and differences. Ultimately, I aimed for an end point where I would have a ‘rough idea of the major achievements in the reviewed field, the main areas of debate, and the outstanding research questions' (Pautasso, 2013 p.2).

Review of the Literature: Approved Social Workers (ASWs) and Approved Mental Health Professionals (AMHPs)

Overall, the search returned 95 potentially relevant articles. I included research pertaining to the ASW role (in England and Northern Ireland) as well as AMHP material. For the purposes of this narrative review there is no significant difference between roles. In England, differences between ASW and AMHP are either around statutory function (with less relevance here) or in relation to the extending of the role from a social work only one, which is covered below.

Stress and burnout

A clear, significant factor in the reforms to the 1983 MHA Act was that ASWs were experiencing high levels of stress and burnout and the creation of the AMHP role via the 2007 revisions was a response to this. ASWs were decreasing in numbers and were difficult to recruit (Hudson and Webber, 2012). ASW and AMHP work has long been experienced as emotionally difficult and mentally draining with stress and low morale (often attached to recruitment and retention problems) being continually cited as a core problem (Barnes et al., 1990; SSI, 1991; Stevens et al., 2018; DHSC, 2019). The research undertaken during the planned revisions to the 1983 Act (Evans et al., 2005; 2006; Huxley et al., 2005) found low morale and high levels of stress, with over two thirds of ASWs experiencing a high level of emotional exhaustion. ASWs were more vulnerable to common mental health problems, with 43% at the threshold for depression and anxiety. ASW status was seen as an indicator of job satisfaction and ASWs were more likely to want to leave the job, with a quarter having clear plans to leave (Huxley, 2005; Evans et al., 2005). There was an ageing workforce, physical health impacts arising from a stressful role, particularly amongst males, and a high level of burnout (defined as exhaustion from excessive demands on energy and personal resources) with, in particular, depersonalisation in relation to people who use services being more common.

Additional burdens included: more hours on duty and consequently not offering acceptable levels of care to people on their existing caseload; limited choice about taking on the ASW role; less support at work (particularly from supervisors) and a role with less decisional latitude, due to options being constrained by the legislative framework and by limited availability of alternatives to admission (Evans et al., 2005). MHA assessments were extremely time consuming and ASWs were frequently required to work into the evening and night, in isolation, and with no capacity to take time off in lieu given staff shortages (Huxley et al., 2005).

Stress amongst AMHPs continues to be high as statutory work becomes 'increasingly squeezed' (DHSC, 2021). The lack of resources (including the availability of ambulance, police and doctors) has led to delays and late working, although the lack of beds continues to be the most problematic area (Morriss, 2015; CQC, 2016, BASW, 2016; Stevens et al., 2018; Hemmington et al., 2021). Perceptions of fear and risk have been specifically related to co-ordination responsibilities and AMHPs report feeling vulnerable due to isolation, exposure to violence and aggression and lone working (Davidson and Campbell, 2010; Bowers et al., 2003; Quirk et al., 2003; Coffey et al., 2004; Hudson and Webber, 2012) and, further, the absence of a lone working policy is a concern in some areas (DHSC, 2019; Stevens et al., 2018). Burnout continues to be reported, described by AMHPs as colleagues having 'no feelings behind their eyes', although there is a recognition that this could happen to anyone due to the trauma involved in the work (Hemmington et al., 2021 p.56).

Approved Social Worker (ASW) to Approved Mental Health Professional (AMHP)

Consideration had been given to broadening the workforce from a social work only role from the mid-1990s where it was suggested that probation officers could undertake the work (Huxley and Kerfoot, 1994). The formal change was made through the 2007 revisions to the Mental Health Act (1983) and had been informed by national surveys which outlined the difficulties listed above suggesting a need to make appropriate use of relevant skills that were available elsewhere (MHAC, 1999; Kendell and Pearce, 1997; Evans et al., 2005; 2006; Huxley et al., 2005; Audit Commission, 2008; Laing, 2012; Coffey and Hannigan, 2013). Generally, there were concerns over the adequacy of the existing community provisions and the training of the current staff, and, essentially, supply was not meeting demand (Hargreaves, 2000; Furminger and Webber, 2009; HoC, 1982), in turn creating an immediate labour supply stagnation (Fish, 2022b).

The AMHP role came into effect in November 2008 and professionals other than those from a social work background (mental health and learning disability nurses, occupational therapists and psychologists) were able to begin training in 2009 (Hewitt-Moran and Jackson, 2009). The broadening of the AMHP role to include other professionals created mixed views and some unease (Rapaport, 2006; Jones et al., 2006; Jackson, 2009). The unique, independent, rights-based approach and social perspective of the social work contribution to AMHP practice was submitted as a rationale for continuing with the ASW role (Ramon, 1992;

Evans et al., 2005; Bailey and Liyanage, 2012). There were concerns that the value-base and anti-oppressive and anti-discriminatory foundations would be compromised due to the lack of independence from medical influence and perspectives and the need for associated safeguards (Bartlett and Sandland, 2014; NIMHE, 2006; Jackson, 2009). The extent to which mental health and learning disability nurses would be willing to shoulder the increased legal responsibility and accountability was also questioned (Laing, 2012).

There were concerns over the differences between health and social work ethical approaches to the use of compulsion. A study by Steinart et al., 2005 concluded that social workers and psychologists in different European countries repeatedly recorded lower compulsion rates than psychiatrists, nurses, other professions and lay people (Steinert et al. 2005). There was a concern that these results would be replicated within the AMHP role, and that nurses and occupational therapists would not be able to untangle themselves from the 'paternalistic' nature of their medical training. This led to questions around the feasibility of nurses promoting the social model (Rapaport, 2006). Independence from medical colleagues may mean crossing into 'social work territories and values', creating tensions and identity confusion (Coffey and Hannigan, 2013 p.1423). Further, the introduction of AMHPs may increase the power of the consultant psychiatrist and the bio-medical perspective through institutional collusion (Nathan and Webber, 2010). There were strong assertions that the potential loss of the particular social work perspective must be countered by stringent training requirements (MHAC, 2003; Rapaport and Manthorpe, 2008).

The AMHP role has not, however, been embraced by non-social workers in the way the government expected, including by nurses who were not predicted to be hesitant (Rapaport 2006; Campbell, 2010; Bailey and Liyanage, 2012; Bailey, 2012) given that it could be seen, by them, as an opportunity for career enhancement, with, as viewed within social work, additional status as an autonomous step forward away from medicine (Laing, 2012; Coffey and Hannigan, 2013; Stone, 2019). An informal survey of national AMHP local authority leads (Bogg, 2011) found that 72% of local authorities had not extended their recruitment of AMHPs to non-social workers. Currently, registered social workers continue to make up the vast majority (95%) of the AMHP workforce with 4% registered nurses and less than 1% occupational therapists. More than half (59%) of local authorities employ social workers only (Skills for Care, 2022) and only one psychologist is believed to have been approved to undertake the role (NHS Benchmarking and ADASS, 2018).

The AMHP role is often not attractive to nurses, occupational therapists and psychologists for personal, cultural and structural reasons (NIMHE, 2008; Stevens et al., 2018). These include cultural differences between health and social care services, limited access to training, contractual agreements with balancing the AMHP and nursing role creating conflict (the AMHP function is a local authority responsibility), a perceived lack of understanding or support for the role by NHS trusts, disincentives around equal or competitive salaries and de-integration of services making it more isolating (NIMHE, 2008; Bogg, 2011; ADASS, 2018; Stevens et al., 2018; CQC, 2018). Occupational therapists have reported not feeling valued and, overall, there are pressures arising from the nature of (de)integration in mental health services (Morriss, 2015; Woodbridge-Dodd, 2018). There is, however, some coherence and overlap between the respective value bases of social work and occupational therapy (Knott and Brannigan, 2013) as well as professional skills that complement the AMHP role in avoiding admission (De Feu, 2012; Bloodworth-Strong, forthcoming 2023). Explanations for the low uptake by clinical psychologists are sparse but one suggestion is that using compulsion (potentially a form of re-traumatisation) would adversely affect a relationship which rests on a basis of informed consent, trust and disclosure rather than acting as an 'agent of the state' of whom people are very wary (Holmes, 2002). A concern about statutory work damaging the professional relationship has also been raised by nurses (Eastman, 1995; Laing, 2012; Coffey and Hannigan, 2013). This remains an under-researched area, with a small amount of evidence suggesting that the professional relationship could be strengthened, could sometimes require rebuilding but at times was indeed irrevocably damaged (Hurley and Linsley, 2006) or has, at least, led to 'distrust' (Abbott, 2021).

By way of balance, there had been some support for the new role where some social workers welcomed the potential to have more staff taking on the statutory responsibilities of ASWs because it would boost the strength of existing teams (NIMHE, 2008) and there was also a potential strength where non-social work AMHPs could add to the diversity and quality of the role (Jones et al., 2006).

The problem of resources

It is an AMHP's statutory imperative to apply principles of least restriction, to look at all alternatives to admission and to consider hospital as a last resort. Compromises around this have been a consistent theme in the ASW and AMHP literature arising from the significant and ongoing reduction in mental health resources, including in crisis and home treatment teams (Barnes et al., 1990; Hudson and Webber, 2012; Crisp et al., 2016; CQC, 2018; Stevens et al., 2018). Alternatives to admission, therefore, are not used as envisaged when the 1983 Act was passed (Barnes et al., 1990; Quirk et al., 2003) and Prior's (1992) early critique that community services have 'not expanded at the same rate as hospital services have contracted' (p.106) has been significantly worsened by the global recession and austerity measures adopted in the UK (Mental Health Foundation 2016; CQC, 2018).

The original purpose of crisis teams was to reduce in-patient bed use and to provide an alternative to admission, but this has generally proved not to be the case (Furminger and Webber, 2009; Dunn, 2001). Further, ASWs' and AMHP's collaboration with crisis teams has been problematic in terms of the understanding of their role, access, co-ordination, lack of availability of colleagues and these problems can be exacerbated by differing working routines, professional methods, styles and approaches and with problems of attitude or relationships (Quirk et al., 2003; Furminger and Webber, 2009; Hall, 2017).

Difficulties within multi-disciplinary working has been seen to undermine ASWs' decision-making processes and abilities as well as creating further distress for service users and their carers (Bowers et al., 2003; Fakhoury and Wright, 2004; Furminger and Webber, 2009; Davidson and Campbell, 2010). This was particularly relevant in relation to input from GPs (Bean, 1980; Davidson and Campbell, 2010). Difficulties in obtaining appropriate transport and co-ordinating the ambulance, doctor and police to attend at the same time are long-standing and ubiquitous (Bean, 1980; Booth et al., 1985; Prior, 1992; Ulas et al., 1994; Campbell et al., 2001; Bowers et al., 2003; Fakhoury and Wright, 2004; Furminger and Webber, 2009; Davidson and Campbell, 2010; Morriss, 2015; Stevens et al., 2018; CQC, 2018). Interprofessional tensions are also likely to be exacerbated in organisational contexts where resources are scarce, for example around transporting detained individuals to hospital, particularly if both police and ambulance officers are required for this process (Quirk et al., 2003; DHSC, 2019). AMHPs have argued that greater investment in preventative mental health services (including crisis services and non-medical alternatives to hospital) and 'low intensity' support would help to mitigate the impact of social risk factors on mental health and be more effective than legislative change (Bonnet and Moran, 2020).

Problems with hospital beds

AMHP work rests on a social perspective which is rights-based and justice-focused, yet it is eroded by systemic conditions which highlight the challenges to applying these in practice (Karban et al., 2021). The decline in available hospital beds has made risks difficult to manage (Lelliot and Audini, 2003) and, as above, finding a hospital bed for those liable to be detained is now cited as being the most problematic area of practice (Hudson and Webber, 2012; Morriss, 2015; CQC, 2016, BASW, 2016; Hall, 2017; Bonnet and Moran, 2020; Hemmington et al., 2021), even though this is not actually part of the AMHP's duties (DoH, 2015a para. 14.77).

The lack of hospital beds goes beyond a practical, processual problem. AMHPs experience ambivalence where a 'best interests' position supports the idea that a service user is not the best judge of their own best interests and their role, representing the paternalism of the state, is a positive and even benign, force (Nathan and Webber, 2010; Fistein et al. 2016). Statute gives the AMHP the authority to arrange a safe place to people in distress, offering relief when they lack capacity to meet their own needs (Thompson, 1997). The ASW or AMHP acts as container for the disintegrative forces of a 'mental illness' and the 'cure' may be seen by the ASW or AMHP as admission to the asylum of a hospital bed however this is denied to them if no such bed exists (Thompson, 2003). In this situation, AMHPs experience guilt and anxiety from having to 'walk away' (Morriss, 2015; Vicary, 2017; Hemmington et al., 2021). Inevitably, the inability to meet service users' needs affects stress and morale (CQC, 2018; Skills for Care 2018).

Problems with detention in hospital

AMHPs' experience ambivalence even where a bed can be found. Hospital admissions have historically been associated with perceived poor support from families and poor communication between professionals (Barnes 1990; Booth et al., 1985; Dunn, 2001; Quirk et al., 2003). More recently, albeit a relatively under-reported and under-researched area, AMHPs describe conflict arising from their parallel distrust in the institution that is proposed as offering asylum in the true sense of the word - the hospital (Morriss, 2015; Abbott, 2021). AMHPs may believe that the person needs to be in hospital but are simultaneously aware that the wards are often bleak and sometimes dangerous places to be (Morriss, 2015; Quirk et al., 2003), and are 'unpleasant' and 'un-therapeutic' and they attest to becoming 'numbed out' to cope with the 'half-truths' they are telling people about recovery (Hemmington et al., 2021, p.65). The harm caused by admission represents an inherent contradiction in AMHP work (Morriss, 2016) and an ethical dilemma where internal conflict and cognitive dissonance is also generated (Skinner, 2006). This highlights the inherent care/control difficulties attached to the work (Yianni, 2009; Buckland, 2016) where AMHPs often shift their moral position and personal values as a way of rationalising and managing their role (Buckland, 2016: Simpson, 2020).

AMHP work as ‘morally injurious’ work

AMHPs seek social justice but are now oppressing people, experiencing a ‘moral injury’, are placed in ‘morally dubious situations’ and carry a sense of guilt about the role they are ‘pushed’ into pursuing (Hemmington et al., 2021 p.65)[10]. In this same research project, they described being pushed into using warrants and detaining people too frequently and this was particularly linked to outcomes for people from Black and Minority Ethnic/non-white backgrounds, making it hard to enact justice under these circumstances.

AMHPs’ power and independence are therefore ‘illusory’ in that they are dependent on the availability of resources (Prior 1992, Quirk et al., 2003). For example, ASWs and AMHPs may find, in the absence of resources, that their only power becomes that of detention (Kinney, 2009; Hall, 2017) which is counter to their professional imperatives around finding alternatives to admission and this is a key conflict. The limited choice of alternatives to admission is deterministic (Haynes, 1990; Quirk et al. 2003; Buckland 2014; Stone 2019; Glover-Thomas 2018) and is compounded by a lack of sufficient time and by pressure to resolve the situation (Quirk et al., 2003). The overall 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 (CQC, 2019) where the majority of admissions would have been avoidable with the provision of alternative services (Booth et al., 1985; DHSC, 2019). The rising instances of detention may be understood as AMHPs utilising the ‘safe’ option by detaining people (Quirk et al. 2003; Stone 2019) but essentially people are being detained by default rather than by necessity (CQC, 2018) and in this sense, resources are a proper concern of mental health law with a human rights orientation (Walton, 2000). Detention has become an ‘overused last resort’ (Bonnet and Moran, 2020) as AMHPs feel forced to compulsorily detain (HoC, 2013; Hemmington et al., 2021). Applying for detention in the absence of alternative resources has been described as a ‘personal failure’ (Kinney 2009, p. 334). AMHPs lament their being seen to provide only a ‘sectioning service’ at the expense of therapeutic work (Webber, 2013) and a service where control and containment are prioritised over treatment and care (CQC, 2016).

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[10] Moral distress arises when constraints make it impossible to do the ‘right thing’ and professionals may perpetrate, fail to prevent, or witness events that contradict their deeply held moral beliefs and expectations (Jameton, 1984). Ethical dilemmas, moral conflicts and the inability to prevent suffering are among the most commonly identified stressors precipitating moral injury (Farnsworth et al., 2014) as these contradict our personal moral beliefs, causing dissonance and inner conflict (Litz et al., 2009).

AMHP work as emotionally challenging work

The ‘emotional challenges’ of the work have been described as ranging from ‘horror’ (around the detentions and loneliness) to the ‘buzz of the job’ (within the context of providing good care in challenging circumstances or redressing discrimination or oppression) (Hurley and Linsley, 2006). Uncertainty, in terms of whether an assessment will be allocated as well as the different types of situations AMHPs may have to manage have been described as ‘exciting’ and ‘adrenaline inducing’ and a ‘rollercoaster’ (Gregor, 2010; Hemmington et al., 2021). Being cast into a ‘bad guy’ role by other mental health professionals can be stressful (Hurley and Linsley, 2006) as is the morally dubious and anomalous nature of the ‘policeman(sic)/executioner’ role and the interpretation that ‘MHA assessments are a bit like funerals: ‘no-one likes doing them, but they’ve got to happen’ (Quirk et al., 2000 p.38). The same ASWs also referred to themselves as the ‘stormtroopers of the psychiatric system’ and made reference to transporting detained people to hospital as ‘shipping the body’ (Quirk et al 2000, p.45). Dwyer (2012) also highlighted the ways in which the detention process can feel like a ‘barbarity’ (p. 350).

As above, guilt, anxiety and the phrase ‘it really weighs on me’ have been invoked, although there is also a perception that this is how it should be given the gravity of potential outcomes for people (Morriss 2016, p. 709). Vicary (2017) introduced the ‘feeling rule dichotomy’ whereby conflicting emotions are used to control practice and guilt may be used alongside pride to give due weight to a decision. Yet fear, particularly around lone working, has been understood to influence decisions about detention (Huxley et al., 2005; Quirk, 2000; Davidson and Campbell, 2010).

Emotional labour

The concept of emotional labour (Hochschild, 1983) has been used to illustrate the ways in which ASWs and AMHPs process intensely powerful emotions and feelings whilst managing and containing individuals’ and families’ stress and trauma as they manage and co-ordinate complex assessments, risky situations and wait for support from other colleagues (Gregor, 2010; Hudson and Webber, 2012; Morris 2015; Allen et al., 2016; Vicary et al., 2019). Many ASWs cited stress and the emotional impact of the work as being the most difficult aspect of the role, although only a small number explicitly identified this which suggests that ASWs are often unaware of the emotional labour that they were undertaking. Thompson (2003) similarly highlighted the ways in which ASWs attempts to manage their emotions and project their authority and control over a crisis whilst, at the same time, supporting people's profound internal distress.

Dirty work

Within the literature, the concept of 'dirty work' is allied to the emotional labour attached to ASW and AMHP work. The social control function of the role has been explored within a context of 'dirty work', explained as the lack of opportunity to help or to do anything *for* someone, in a therapeutic sense, and instead having to do something *to* them, in a coercive sense (Hughes, 1971; Emerson and Pollner, 1976; Bean, 1980; Morriss, 2015; Vicary, 2019). This is part of working in an occupation in which one may be 'compelled to play a role which he ought to be a little ashamed of morally' (Hughes, 1971 in Quirk et al., 2003). Morriss (2015) viewed this social control function of the role in terms of 'dirty work' whereby difficult and 'dirty' work relates to the lack of beds, the complexities of coordination (including the lack of availability of the police), the act of detention, the lack of legal knowledge of some colleagues and being 'shouted at' by Accident and Emergency staff due to the lack of transfer beds and facilities.

Overall, the work can be traumatic and overwhelming (Thompson, 2003, DHSC, 2019; Abbott, 2021) yet the emotional aspect of the work is often not discussed (Dwyer, 2012).

Supervision and support

A consistent theme in the literature has been poor leadership and management, lack of opportunity for formal supervision and debriefing, erratic levels of supervision and an over-dependence on peer support (SSI, 1991; Furminger and Webber, 2009; Gregor, 2010; Hudson and Webber, 2012; Hemmington et al., 2021) despite the fact that 'feeling valued' is associated with better mental health, less emotional exhaustion, less depersonalisation and higher job satisfaction (Huxley et al., 2005; Gregor, 2010). Peer group discussion is one way in which ASWs and AMHPs are sustained (Quirk et al., 2000; Hemmington et al., 2021) as the emotional demands, stress and anxiety of carrying out statutory work are often unacknowledged and unrewarded by other means, including by managers (Gregor, 2010). Regular, challenging supervision is crucial for supporting AMHPs to understand when, how and why emotions - including fear - impact decision making (Collins and Daly, 2011; Vicary et al., 2019; Allen and McCusker 2020).

Where AMHPs recognised the emotional impact of their role and the ways in which it is traumatic, using descriptions such as an ‘emotional battering’ and a ‘raw role’ (both for themselves and the people they assess), there was a view that engaging ‘with our own feelings’ makes you a better AMHP but it is at a cost (including exhaustion) and there is no protection ‘in the system’. This is presented in the literature within a context of poor or absent supervision. This aspect of the work is not discussed within supervision, either because it is not available or because AMHPs ‘avoid their own psyche’ that brought them into the work (Hemmington et al., 2021 p.56).

The invisibility of the AMHP

AMHP practice is often viewed a solitary concept, arguably contributing to the lack of attention to the systems in place to support it. AMHPs are not ‘owned’ by one national body; rather their practice transcends numerous organisations, professional bodies and communities of interest (HEE, 2017). Consequently, the role is low profile. At a national level, and in terms of policy, it has not been given the full support, recognition, review and structure that it requires in order to be completely effective (Evans et al., 2005; 2006; BASW, 2016; Morriss, 2017; ADASS, 2018; CQC, 2018; Stevens et al., 2018; HEE, 2019; Hemmington et al., 2021). At a local level, there is a perceived lack of understanding or support for the role by NHS trusts and a lack of support for ‘health-based’ AMHPs from some local authorities as well as cultural issues between health and social care (Stevens et al., 2018). ASWs and AMHPs have reported feeling undervalued, receiving little recognition and feeling poorly paid, both in comparison with other professionals involved in MHA assessments and given the level of responsibility the role confers (Huxley et al., 2005; DHSC, 2019; Hudson and Webber, 2012; Hemmington et al., 2021). AMHPs show frustration and anxiety at being ‘abandoned’ where they can be literally left on their own at the scene, experiencing this as being left to undertake tasks with low prestige (Vicary et al., 2019; Hemmington et al., 2021). Many ASWs also believed that their role was misunderstood by the people who use services and their families (Gregor, 2010).

Professional identities and values

Relationships between AMHPs’ regulated profession roles (i.e. social work, nursing, occupational therapy and psychology) and the ways in which they carry out the work have been explored. Bressington et al (2011) evaluated differing professional viewpoints and levels of knowledge held by social workers and nurses during training concluding that, initially, social workers had a greater understanding of the role but, on completion, both groups demonstrated similar levels of learning. Similarly, Stone (2019) explored the differences between social workers and nurses and the ways in which socialisation through AMHP training has an impact on professional values, principles and paradigms. AMHPs' decisions and views may differ, but this is related to a variety of individual subjective differences, experience, human agency and individual construction of risk rather than necessarily being about professional background. In contrast to the stereotypes, nurses were not preoccupied with medication in their risk assessments, while social workers seemed more focused on medication than anticipated. Social workers did not highlight social factors to a greater degree than nurses in their assessments and all participants demonstrated their adherence to the principle of least restrictive practice when looking for proportionate alternatives to detention. Overall, the human rights approach, social perspective and specific value base does appear to have been retained, regardless of professional background (Buckland, 2016; Dixon et al., 2020; Laing et al., 2018; Hemmington et al., 2021). Vicary (2017) indicated that it is a person's attributes that attract them to the role.

The role is understood to have a human rights and a social approach at its heart and considerations about human rights are dominant within AMHP decision-making (Buckland, 2014; Dixon et al., 2020; Laing et al., 2018). AMHP services are required to promote the dignity, human and civil rights of those it encounters (including paying attention to racial and cultural disparity) and AMHP practice is founded upon the promotion and protection of social values, equality, and autonomy both individually and at a structural level through developing methods of co-produced service delivery (HEE, 2017). AMHPs assert that as part of the professional value base, which is founded on anti-oppressive and anti-discriminatory practice, there is a requirement to challenge where necessary (Gregor, 2010; Morriss, 2015). Research highlights ASWs' propensity to act as a 'brake' on clinicians' decision to detain, as well as their own professional, or even personal, value base albeit being perceived as them resorting to a 'higher authority than the law' (Peay, 2003 p.46).

AMHPs have described a unique form of practice wisdom, expressed as 'the way that you think', and report that becoming an AMHP is a rite of passage, with the worker achieving a higher status arising out of the additional 'mental power' and reflective practice required to manage the complexity and ambiguity of the work (Morriss, 2015). The work is seen as prestigious and higher-status, requiring advanced skills and the ability to manage very complex situations (Gregor, 2010). Personal identity and professional identity are congruent and decisions are more than technical or part of a role; it is intrinsic to identity (Skinner, 2006; Morriss, 2015; Vicary, 2017). Similarly, ASWs 'embrace and personalise the role, rather than attempt to separate it off as a part that they were required to act by their employer' (Gregor, 2010 p. 435).

Professional identities in practice

A recurring theme is that ASW and AMHP practice takes place in uncertain, chaotic circumstances where the role consists of 'on-going contingency management', task-juggling, improvisation, cajoling and persuasion (Quirk et al., 2000). In this same research, ASWs were seen to have multiple roles: 'applicant' (their 'official role' as signatories of the application); 'social worker' (in the context of an existing professional-client relationship causing conflict and feelings of betrayal); 'care manager'; 'supervisor/trainer'; 'advocate'; 'hate figure'; 'therapist' (around informing the client of their right to appeal, thereby attempting to facilitate client control and counter the damaging effects of compulsory admission by exercising a right to be listened to); '(social) policeman(sic)-executioner' (locking people up against their will and evidencing the social control function); 'bureaucrat' ('following the rules' and presenting detention as 'nothing personal' to minimise its harmful effects on existing relationship or to counter perceptions of the 'policeman/executioner' role); 'ongoing contingency manager' (a core role due to common unexpected turns of events) and 'impresario' (a key role to successfully 'stage manage' the assessment and make sure it runs smoothly). Tensions exist where various roles may be evident in a single assessment, e.g. there may be a quick transition from the ASW's perceived role as 'social worker' to that of 'hate figure' once the person is told they are going to be compulsorily detained – also, significantly, raising the question of 'whose side are you on?'. Leah (2020) more recently revisited this approach and added further overlapping roles when discussing AMHPs' 'hybrid' roles. Ultimately, MHA assessments represent an interface between the differing worlds of legislators and mental health professionals (Quirk et al., 2003).

Dual functions, social control and blame

Stress and pressures arise from the perception that AMHPs are 'agents of social control' who are challenged to balance the needs of the state, the wider public and the person themselves (Thompson, 2003; Campbell, 2010) and this 'custodial function' of the role has been seen as an inevitable trade-off of values (Chan, 2002).

Ethical dilemmas appear where statutory duties may be contrary to AMHPs' and ASWs' emancipatory values and aspirations to act as advocate (Prior, 1992; Wellard, 2001; Quirk, 2003; Lepping, 2007; Hatfield, 2008, Yianni, 2009). Conflict, anxiety and tension is found where ASWs and AMHPs are personally liable for their actions yet, at the same time, are a representative of their local authority (Thompson, 2003). It has also been argued that there is a tendency towards more technical and legalistic approaches to decision-making where ASWs and AMHPs tailor their judgements around personal concerns about litigation and societal pressures to protect both individuals and the wider public (Jaconelli and Jaconelli, 1998) and the decision to detain is driven by fear of the consequences of not detaining (in relation to risk) and the accountability attached to this (Peay, 2003). This pressure to avoid risk taking due to organisational and socio-political 'blame culture', includes being challenged by peers who see detaining as a 'low risk' option (Quirk et al., 1999; 2003; Hudson and Webber, 2012; Hemmington et al., 2021). Certainly, accountability is felt more critically following public inquiries apportioning blame and responsibility and the risk of political opprobrium (as opposed to a risk of violence or suicide) (Thompson, 2003; Vicary, 2017; Stone, 2019).

Independence

Whilst they have the 'final say', ASWs have questioned the extent to which they feel constrained from 'going against' the medical recommendations due to the potential to damage inter-professional relationships and any spirit of local co-operation and joint-working (Quirk et al., 2000). Team support in decision-making has been significant in that ASWs indicated that they were more likely to take a risk (and not detain someone) if they knew that they had their team's support, as this can require a certain amount of 'nerve' when the decision is a 'borderline' case (Quirk et al., 1999). Interestingly, given the earlier overview around stress and burnout, fatigue has been identified as a barrier to thoroughly investigating a situation and with a tendency to agree with doctors (Haynes, 1990).

Authority, autonomy and power

Ideological differences between health and social services have led to communication being defined in terms of resistance and struggle for control, with ASWs and AMHPs deliberately using their power 'as a tool for good' in MHA Assessments to minimise the influence or dominance of the 'medical model' (Rabin and Zelner, 1992; Colombo et al., 2003; Morriss 2015; Buckland, 2014; Hemmington et al., 2021). Pressure on, and attempts to influence, ASWs' decision making has been observed from GPs (Haynes, 1990), from nurse colleagues (Quirk, 2007) and from employers (Thompson, 1997; 2003; Skinner, 2006; Campbell, 2010). Crucially, Booth et al (1985) indicated that avoidable admissions were seen as being problems of collaboration including problems of attitude or relationships between ASW and doctors. Certainly, in cases of disagreement, and where the AMHP takes a stand against medical colleagues' opinion, they bear the responsibility and any consequences alone (Davidson and Campbell 2010; Bailey and Liyanage 2012; Vicary, 2017).

Yet ASW and AMHP duties and powers were intended to be complementary rather than subordinate (DoH, 1993) and it is incumbent upon them to assure themselves of the lawfulness of the medical part of the process, hence the generally held view that the role includes safeguarding people's civil rights (Walton, 2000). Unsurprisingly, then, AMHPs indicate that 'the best personality type' to undertake AMHP duty is one of being 'strong, assertive and able to challenge doctors' and that they need to use power in a way that distinguishes them from other professionals in MHA assessments (Gregor 2010; Morriss 2015; Buckland, 2016). They use their power to balance that of the medical profession in respect of a social risk rather than a mental health orientation (Anderson-Ford and Halsey, 1984) although this can be problematic particularly in the face of competing organisational and resource demands that reduce opportunities for proactive, empowering engagement and advocacy for the individual (Prior, 1992; Campbell 2010).

Rewards and motivation to undertake the work

Factors identified by AMHPs as motivating them to undertake the role include career progression (including independence), further training, professional development and status, a clearer professional role within multidisciplinary services, the opportunity to 'sensitively' apply the power and authority of the AMHP to complex real-life situations and enhanced job security (Hudson and Webber, 2012; Watson, 2016; Stevens et al., 2018). Some value the MHA assessment as a contained piece of work with a high degree of professional discretion, and with scope to exercise independent judgement and with the authority and opportunity to resolve crises for individuals and their families (Watson, 2016; Gregor 2010). It is, however, also often part of a contractual obligation and a requirement of employment and career progression for local authority social workers (but not nurses) (Gregor, 2010; Hemmington et al., 2021).

AMHP work has been viewed as prestigious (Gregor, 2010; Morriss, 2015; Hemmington et al., 2021) and it encompasses a sophisticated use of emotion in the fulfilment of the role (Vicary, 2021). As AMHPs coordinate the assessment process and are responsible for the outcome, it is indicative of a 'Lone Ranger' persona - someone who arrives out of nowhere to challenge injustice and bring order to chaos (Gregor, 2010). All AMHPs appear to identify the professional values and opportunity to assert a social perspective, protecting the rights of vulnerable individuals, as motivating (Gregor, 2010). 'A difficult job done well' and a 'good piece of work' is often found where the ASW or AMHP has been able to use therapeutic skills and crisis intervention techniques to avoid hospitalisation, particularly 'breaking the cycle' of compulsory admission (Quirk et al., 2000; Huxley et al., 2005; Morriss, 2015). AMHPs are also rewarded (and in many respects sustained) by peer support (Gregor, 2010; Hudson and Webber, 2012) and feeling valued is also associated with increased job satisfaction (Huxley et al., 2005).

Training and Education

There are gaps and deficits in AMHPs' education, training and information needs (Fakoury and Wright, 2004) as qualifying criteria are based on formal, prescribed statutory competences (Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008. The adequacy of competence-based approaches in preparing practitioners for professional judgements has been questioned (Walton, 2000) as functional education methods do not sufficiently incorporate generic social work skills and knowledge sufficiently (Thompson, 1997). Training could be less mechanistic and focus more on contemplation, reflection, the discomfort attached to uncertainty, (Parkinson and Thompson, 1998), the therapeutic relationship, particularly at times of crisis (Thompson, 1997), and the 'emotionally provocative' nature of the work (Hurley and Linsley, 2006). This latter research also suggested that training directed at understanding 'relationship impact issues' for nurses might be helpful. Crucially, it has been suggested that ASWs who feel inadequately trained and supported in the more subtle skills of their own profession may be more likely to defer to practitioners of more highly codified disciplines, such as psychiatry and the law, contrary to the statutory formulations of their roles (Sheppard, 1995).

Decision-making

Decisions about detention are not, however, based solely on technical judgements; they are subjective, interpretive and 'infused with morality' in the way they draw together AMHPs' personal and professional domains including emotions, intuition and uncertainty, juxtaposed with fear of responsibility and risk aversion (Peay, 2003; Skinner, 2006; Buckland, 2016; Glover-Thomas, 2018; Simpson, 2020). Conflicting emotions around the 'right or wrong decision' have been noted (Dwyer 2012; Buckland, 2014; Morriss 2016; Stone, 2019). Glover-Thomas (2011) and Stone (2019) indicated that decisions were somewhat intuitive, although this is hard to articulate. Similarly, Buckland (2014) found AMHPs using the term 'common sense' to describe their decision making. AMHPs use themselves as a resource in decision-making in the ways in which they integrate intuition with morality (Simpson, 2020).

Peay (2003) identified different philosophical styles and decision-making processes that led to different recommended courses of action: there were clinical, legal and ethical decision-makers (p.187). Experience appears to have an impact (Sheppard 1995) and Roberts et al (2002) reasserted that the law is operated on a discretionary basis with organisational and professional attitudes informing decisions. As above, discretion also depends somewhat upon the available resources (Peay et al., 2001).

Perceptions of support from multidisciplinary colleagues could influence ASWs' and AMHPs' decisions through discussion, advice or more tangible task-sharing such as developing community care packages as alternatives to hospital (Quirk et al., 2003; Wickersham et al., 2019). Some ASWs thought lone working would affect decision-making (Davidson and Campbell, 2010). Peay (2003) and Hall (2017) suggest that social workers and medical professionals have a different focus in their assessments and may interpret legislation differently and the historical prominence of the medical approach to mental health care still holds influence, as 'social data' is often considered 'soft data' (Peay, 2003, p. 28) as against the strength of medical diagnoses.

Decision-making contexts have been described where the ASW usually faces 'crisis, mess and muddle' and the application of the MHA often occurs in situations where there is 'panic and confusion' and where a high degree of discretion is required (Parkinson and Thompson, 1998). Quirk et al (2000) similarly presented the MHA assessment as subject to false starts, disruptions, delays and no-shows requiring ASWs' expertise in 'ongoing contingency management', task-juggling, improvisation, cajoling and persuasion. These observations were later reiterated by Leah (2022).

Practice 'models'

The AMHP role is not well-understood which may be due to the lack of evidence and research around the practice knowledge base or model (Dunn, 2001). Given the inconsistencies in outcomes and approaches to assessment, there have been recommendations for 'universal' models of assessment and decision-making around risks (Sheppard, 1990; 1993) to address the 'assumptive world' of the ASW being based on different orientations; a mental health orientation, a presumption of risk or a 'social risk' orientation. However, the schedule was not adopted and AMHPs continue to undertake assessments without a standardised form, guidelines or written 'rules'. As such, the decision is informed by aspects of the AMHP self, their knowledge base and potentially other variables (Sheppard, 1990; 1993). A small number of other models were proposed in light of the pending changes to the 1983 MHA and there was a growing interest in home treatment (Bridgett and Polak, 2003; Peay 2003; Quirk et al., 2003) but again these were not adopted in practice.

ASWs and AMHPs have always covered out-of-hours work as there is a statutory duty for local authorities to provide this cover. Interestingly, given the move towards round-the-clock AMHP services, there is no research available as to whether ASW and AMHP work has been qualitatively different during daytime and night-time. Smith and England (1997) have written generically about Emergency Duty Teams (EDT) with themes that could be applied to AMHPs. For example, EDT workers are understood to be more likely to share discussions and dilemmas with other professionals, including the police and doctors, simply because of their own isolated working and the lack of availability of colleagues. It might be the case that EDT workers, rather than being handicapped by their isolation, are motivated to work in a role that offers more autonomy and freedom. Reference is also made to the influence of the 'shadowy nights' around perceptions of risk. Overall, however, it is as yet unclear as to whether there are different modes of practice within the different teams and services. Additionally, AMHPs practice across rural and urban areas and very little is known about the different conditions and approaches to practice (Murr and Waterhouse, 2014).

AMHP demographics

It has long been recognised that the AMHP workforce is ageing (Evans et al., 2005; ADASS, 2018; DHSC, 2019; Skills for Care, 2021). Current estimates are that 31% of AMHPs are over 55 compared to 23% of social workers and this group may retire within ten years. There are notably fewer AMHPs under thirty years of age compared to social workers (Skills for Care, 2022).

The AMHP role continues to have a higher proportion of people identifying as male (26%) compared to social workers overall (18%) (Skills for Care, 2022) and previous explanations for an over-representation of men in this field of work have focused on pay, power and masculine notions around risk (Rolph et al., 2003).

Concerns have been expressed about the lack of diversity within the AMHP workforce (DHSC, 2019) where AMHPs are less ethnically diverse than social workers overall, with 79% of AMHPs are being white and 21% from racialised communities (Black, Asian, mixed or minority ethnic backgrounds) (Skills for Care, 2022). For comparison, statistics from a 2018 survey indicate that for people who are assessed under the MHA, 76% were from a White British background and 9% were from a Black British, 'Other' or 'Mixed Race' category (CQC, 2018).

AMHPs have a specific role in reducing discrimination and supporting a human-rights led approach for people being assessed or detained (DHSC, 2019), but have struggled with exercising 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 (Webber and Huxley, 2004; NHS Digital, 2020; Abbott, 2021). There is scant evidence explaining the reason for this, perhaps due to the fact there is no detailed research around decision-making at a micro level.

‘Social characteristics’ of people being assessed

Small, localised projects have examined the ‘social characteristics’ of people being assessed and detained (Barnes et al., 1990; Hatfield et al., 1992) and they illustrate the ways in which ‘social factors’ have appeared to inform discriminatory attitudes around detentions. The Department of Health issued an Equality Analysis of MHA outcomes (DoH, 2015b) where the protected characteristics of the Equality Act (2010) were considered in order to highlight how the MHA needs to be monitored in terms of equality legislation. The analysis reviewed all publicly available data, reports, studies and reviews pertaining to the specific protected characteristics. It found that nearly half explicitly considered ethnicity, whilst some areas were sparsely covered (for example in relation to people with learning disabilities being subject to compulsion) and there were no papers at all in relation to sexual orientation, religion or faith which represents a significant gap in knowledge.

Race and ethnicity

Decisions and outcomes of MHA assessments have not consistently recorded race or ethnicity until relatively recently. Nonetheless, all available research reveals the increased likelihood of detention under the MHA for people from an ethnic minority, particularly from Black ethnic groups (Bhui et al., 2003; Singh et al., 2007; MHAC, 2007; DOH, 2015b). In the most recent statistics, the detention rate was highest for those with ‘Any Other Black Background’, which forms part of the ‘Black and Black British’ group, at over ten times the rate for the White British group. The ‘Any Other Ethnic Group’ had the second highest rate of detention followed by ‘Any Other Mixed Background’ group (NHS Digital, 2021). Further, people within the Caribbean ethnic have longer durations of detention, nearly twice the median length of detention for the White British ethnic group (NHS Digital, 2021).

There is understood to be a lack of awareness of the needs of minority ethnic communities (Barnes et al., 1990; SSI, 1991; Huxley and Kerfoot, 1994; Manktelow et al., 2002; Hatfield et al., 1992; Hatfield and Mohamad, 1994, Hatfield et al., 1997; Singh et al. 2007; Gajwani et al., 2010; CQC, 2011; Mental Health Network NHS Confederation, 2014; Singh et al. 2014; DOH, 2015b). Service users' experience of not being heard, being mistrusted and being treated with hostility are commonly expressed and are indicative of implicit power dynamics and coercive (or no) care (Bhui et al., 2018).

The independent review of the MHA was commissioned by the government as an acknowledgement of the inequalities facing people from minority ethnic groups in terms of access to treatment, experience of care and quality of outcomes (DoH, 2018). The review has acknowledged the number of detentions and considered ways of improving the dignity and outcomes for people from racialised backgrounds, recommending that the AMHP should have a key responsibility in protecting and emphasising the human rights of people being assessed or detained, and be trained to provide the best possible assessment and support (DHSC, 2019). There is a recognition, however, that the workforce needs to be more culturally reflective of the people it works with, to understand the effects of discrimination upon them and to be trained to provide the best possible assessment and support. Within this, Bhui et al. (2018) reflected that:

> The lack of recognition and awareness of the role of racism in mental health care, and its role in generating and perpetuating ethnic inequalities, has many consequences … The experience of not being heard, or being mistrusted, or being treated with hostility, are commonly expressed by services users, and reveal implicit power dynamics that act as a context for inequalities. Service users from ethnic minority groups continue to experience poorer care or more coercive care, or no care. These negative experiences are self-fulfilling and sustain the perception of care systems as harmful and obscure more positive experiences (p.32).

The recommendations of the MHA review (DHSC, 2018) for a 'new approach' include the development and implementation of an Organisational Competence Framework and Patient and Carer (Service User) Experience Tool, the provision of culturally-appropriate advocacy to provide a supportive role for individuals of African and African-Caribbean heritage, specific early intervention for people from 'BAME backgrounds' as well as ways of combatting the effect of unconscious bias within the mental health workforce.

Gender

Historically, women have been thought more likely to be subject to MHA assessments and detention (Hatfield et al., 1992, 1997; Hatfield and Mohamad, 1994; Hatfield and Antcliff, 2001) where statutory interventions appeared to be affected by patriarchal assumptions and gendered perceptions about risk (Warner and Gabe, 2008). Medical referrals were associated with a higher proportion of women, particularly those with children, with the suggestion that traditional role stereotypes explained this (Barnes et al., 1990; Sheppard, 2008). GPs have been seen to discriminate against women where the majority of their referrals for a MHA assessment were for women where relationship problems were more detailed and problematic behaviour was cast in a familial or wider social context (Sheppard, 1991; 1992). There is also a slight but significant bias towards using sections of the Act resulting in shorter detention periods of up to 28 days for women, rather than longer up to six-month periods which may be due to perceptions around caring responsibilities (Beezhold et al., 2013). The lower age expectancy of men thought to account for the increased numbers of older women detained (Hatfield et al., 1997; Audini and Lelliot, 2002).

More recently, however, the increase in detentions has been greater for men, particularly younger men (Dunn, 2001; Lelliott and Audini, 2003; Mental Health Act Commission, 2006, NHS Digital, 2021). It may be that the increasing number of men being assessed and detained reflects the emphasis on public protection and risk awareness that has been prominent in English mental health policy more recently (Hatfield, 2008).

Social determinants

The above information represents a small number of variables and structural inequalities at the intersection of MHA decision-making and detention. Socio-economic status and access to social and cultural capital, suggesting that certain people are more likely to become subject to the use of compulsory powers. Hatfield (2008) also found low income, poor material resources, high levels of social exclusion and isolation and lifestyle issues such as drug and alcohol misuse were significant. Sheppard (1991; 2008) refers to the ‘social insecurity’ of many service users subject to the MHA assessment process – those with unstable housing, unemployment, poor or deprived financial circumstances and low levels of social, particularly familial support Hatfield et al., 1997). Requests for compulsory admission have been viewed as a consequence of the service user’s breakdown in social situations or lack of social support as much as an intrinsic ‘need’ to be in hospital (Barnes et al., 1990). Hatfield and Antcliff (2001) therefore conclude that increasing rates of MHA detentions cannot be separated from broader considerations of social welfare and the provision and allocation of health and social care resources. It continues to be the case that rates of detention increase with deprivation, where detentions in the most deprived areas have the highest rates of detention, equating to three and a half times higher than the rate of detention in the least deprived areas (NHS Digital, 2021).

AMHP work as social and relational

AMHPs are required to undertake the work from a social perspective, with a knowledge-base resting on social determinants of mental ‘illness’, and with an understanding of mental ‘illness’ as a social construction which is embedded in AMHPs’ practice (Karban et al., 2021; Fish, 2022a). Hall’s (2017) framework analysis indicated that AMHPs’ concepts or frames of risk were explored in terms of social crisis social problems, complex relationships and coping mechanisms and a ‘normal’ response to a social situation. Conversely, nurses who were part of the team of Home Treatment Professionals (HTPs) tended to focus on the identification of a mental illness, individual pathologies, risk, and labelling people accordingly. However, Buckland’s (2014) research suggested that normative discourses relating to ‘illness’ and ‘treatment’ in hospital are reproduced within AMHPs’ written accounts of their decision-making.

AMHP work is a socio-relational process involving a focus on the person in their environment in relation to others, such as family and professionals (Abbott, 2021) and the MHA assessment is a place where the law weaves coercion and collaboration with the person being assessed (Thompson, 1997). A lack of dialogue with the person assessed being assessed has been a source of frustration for AMHPs (Abbott, 2021) and AMHPs regret not having the time to spend with people and not having the Empowerment and Involvement principle, aspects of shared decision-making and features of coproduction at the centre of the assessment (Hemmington et al., 2021). Only a small amount of research has looked at the nature of communication, apart from the ways in which this can change over the course of an assessment from negotiation to coercion (Quirk et al., 2000).

MHA assessments have an essentially private nature and are undertaken by professionals away from public gaze and without public scrutiny, despite the serious implications for personal liberty (Bean, 1980; Sheppard, 1993). Overall, little is known about how AMHPs communicate with and relate (or indeed fail to relate) to service users, and how this may influence their decision-making. AMHPs are required to ‘think on their feet’ and have a range of skills, and assessments take place in different settings and this appears to have an influence

– assessing an unknown person in a police cell typically has a very different ‘feel’ to an assessment undertaken in the home of a familiar service users where professionals may even be offered a cup of tea (Quirk et al., 2003). As has been highlighted, the variables influence communication and decision-making are multifarious and need further investigation.

Chapter summary

This chapter has set out, through a narrative literature review, many themes that have relevance for AMHPs and this research. These are summarised in Box 1 below.

Summary of the Literature

- There are widespread shortfalls in the recruitment and retention of AMHPs and increasing numbers of assessments and detentions. This has been an ongoing difficulty for AMHP practice
- These are leading to high levels of stress and burnout, physical and mental health impacts and reduced job satisfaction relating to resource restrictions as well as the intrinsic nature of the work
- The lack of alternatives to hospital leading to AMHPs feeling forced to detain, the lack of hospital beds and the concerns around the quality and safety of hospital wards lead to AMHPs feeling guilty
- AMHP work is emotional and AMHPs experience trauma, ambivalence and moral injury, describing a ‘raw role’ and an ‘emotional battering’, but this is often not explored in supervision
- AMHPs represent the paternalism of the state whilst striving for advocacy and approaches based on justice, not least as the MHA has the potential to be racialised and gendered in its outcomes. They want to use their power to advance a social perspective and social justice, in keeping with their value base that is founded on anti-oppressive and anti-discriminatory practice
- AMHPs aim to use their power as a ‘tool for good’, at times deliberately to challenge and to minimise the influence or dominance of the ‘medical model’
- AMHPs experience rewards, generally explained as satisfaction from using therapeutic skills and crisis intervention to avoid hospital, or advocacy
- Increasingly, AMHPs work in different practice settings with different work patterns and very little is known about how, or if, this influences the work

- AMHP work is social and relational, little is known about what happens in a MHA assessment in terms of communication, and much of the research focuses on the structural and organisational aspects of the role
- The AMHP navigates both coercion and collaboration in a MHA assessment, but little is known about how they do this

Overall, AMHPs work in complex and uncertain situations and the various roles and conflicts make them appear ‘angst-ridden but strangely decisive’ (Brown, 2013 p.72)

There are clear themes and tensions that were drawn through to the research phases of this study. Some of these are longstanding, for example resources. This has been problematic in terms of the declining number of AMHPs and the increasing number of assessments reducing the amount of time that AMHPs have available for MHA assessments. Again, AMHPs’ duties and practice imperatives have remained the same in theory, but of interest is if, or how, these affect practice.

In the literature, the high levels of AMHPs’ stress and burnout are almost ubiquitous, and these are bound up in the shortages of hospital beds leading to an inability for AMHPs to carry out a main purpose: to find alternatives to admission. This occupational psychic strain on AMHPs is interpreted in this study as a form of moral injury and the research phases go on to explore the implications of this. It is argued that moral injury, and feelings of guilt are inextricably bound with the idea that, for some, AMHP work is relational work. This has been at the heart of references in the literature to AMHP work as emotional work as well as ASWs’ and AMHPs’ application of concepts of emotional labour and dirty work.

The literature highlights the tensions within AMHP work around a simultaneous positioning as advocate for the service user as well as the face of state paternalism. Again, this is seen within this study as being an aspect of AMHP work as relational work and the research goes on to explore these tensions, particularly around power and empowerment. Overall, this comprehensive and detailed literature review has highlighted some of the significant factors (including personal, professional and organisational contexts) influencing AMHPs’ experiences and, potentially, influencing the decisions they make. To further understand these significant variables, and acknowledging the minimal analysis on the role carried out by AMHPs within MHA assessment scenarios, it is this exploration to which I now turn. This begins with an overview of matters of research ethics in relation to research in mental health settings.

Chapter Three: Methodology

This chapter outlines my rationale for undertaking the research as well as the philosophical and theoretical underpinnings of the study. As part of a reflexive approach, I summarise the ‘natural history’ of my research. The chapter sets out my epistemological and ontological position as part of my overall methodology, as well as the chosen methods that are in-keeping with this. A rationale for the particular methods that were adopted to best deal with the research questions and aims is offered. To recap, these were as follows:

Research Questions:

- What are the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make?

- How could AMHPs facilitate empowerment and promote Shared Decision-Making in the process of MHA assessments?

Aims and Objectives:

To undertake a qualitative study to explore how AMHPs in one English Local Authority arrive at their independent decision under the Mental Health Act 1983.

The study’s objectives are to:

- Explore the perspectives and interpretations of AMHPs involved in MHA assessments
- Explore how AMHPs understand and experience their role in making decisions in MHA assessments
- Understand the dynamics and power relations between AMHPs and service users in MHA assessments and the extent, from different viewing points, to which the ‘Empowerment and Involvement’ principle is implemented

Methodology overview

Methodology pertains to the principles of reasoning we use in making choices about research design including the consideration of appropriate models, methods of data gathering and forms of data analysis in planning and undertaking a research study. In general, it is a ‘theory of how the research proceeds’ (Braun and Clarke, 2013, p. 333). Further,

> methodology matters, because it enables us to ask, and begin to answer … interesting and important questions [and the] 'getting of knowledge' … Methodology matters, then … because it is the key to understanding and unpacking the overlap between knowledge/power (Stanley, 1997 p.198)

Having many times revisited my motivation to begin this research and realising that it has also been a long time in development, my thoughts and feelings were consistent with those of Pelias (2004) where:

> To begin a discussion of a methodology of the heart, it seems only appropriate that I would share where my heart is now. I am drawn to this way of working out of a *feeling of lack* (Pelias, 2004 emphasis added.)

Whilst I do not use the same methods or share Pelias' methodology, I felt compelled to understand more about the 'feeling of lack' here as it touched on something I had felt in terms of my own motivations. Pelias' observations were about the lack of reflexivity and engagement with the human condition, relationships and communication in academic environments and this resonated with my experiences in my own field of (AMHP) work.

I spent time reflecting on my reflexive positioning, motivations and 'horizon of understanding' (Rennie, 2000) as I developed my study. In writing this up and revisiting what I have long wanted to know (and how to find it) I followed Madison's (2011) recommendation to ask a question as fundamental as 'who am I?':

> Start where you are. The experiences in your life, both past and present, and who you are as a unique individual will lead you to certain questions about the world and certain problems related to why things are the way they are. It is important to honour your own personal history and the knowledge you have accumulated up to this point, as well as the intuition or instincts that draw you toward a particular direction, question, problem, or topic – understanding that you may not always know exactly why or how you are being drawn in that direction. Ask yourself questions that only you can answer: what truly interests me? What do I really want to know more about? What is most disturbing to me about society? (p.21)

Hammersley (1993) believes that researchers do not become interested in conducting a particular research project merely after reading the work of other researchers and he illustrated, by explicating his own 'natural history', how his research origins were based on personal and political interests. His acknowledgement of his 'important pre-history' charting his early interest in the topic very much mirrored my own feeling. This notion of history appeared and reappeared as I was developing this chapter and I was encouraged by the idea that sharing my early experiences meant that readers might be enabled to render them, in a way, their own (Leibniz, 1887).

Finally, Silverman (2021 p.527) further develops the idea of a methodology chapter being ‘The Natural History of My Research’. My background, outlined below, is termed my ‘pre-history’ (or ‘anecdata’) and something I returned to throughout as part of a reflexive approach. From the outset I kept a research diary in order to record ideas and challenges, to better understand the personal contexts, the reasons for the research design, and to record how the research was developing. Unexpectedly, this came to include Silverman’s (2021) ‘trial and error’ in the ‘methodological lessons learned along the way’ (p.528). I came to view a ‘natural history’ chapter, based on contemporary fieldnotes, as more likely to make readers ‘insiders’ and to avoid my being an ‘outsider’ in relation to my own work (Silverman, 2021)[11]. I outline this approach, below, as an approach to narration of my research. I then outline my chosen methodology.

The Natural History of My Research:

My Pre-History

I made a choice, over thirty years ago, to work in the mental health field. My first job was in an inpatient unit and I was immediately uncomfortable with the obvious aspects of objective coercion. I was uncomfortable with aspects of communication between staff and in-patients, so I chose mental health social work simply because I was attracted to ideas such as anti-oppressive practice and of self-determination (and, in practice, the lack thereof). Around ten years later I qualified as an Approved Social Worker (ASW) and my practice experiences have continued to fuel my interest in the dynamics of power and decision-making. My move to a university setting followed when, as a Community Mental Health Team manager, I experienced a clash of values (both organisational and personal) so great that I moved to an academic social work setting to revisit and reassess my professional outlook. Here I have developed an AMHP training programme, again fuelled by what I saw as a lack in terms of what I wanted to address. Overall, a concern with the actuality of practice and a belief in the need for policy (and political) change led me to undertake this research project.

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[11] After taking this approach and formalising it as part of my stance, I learned that Morriss (2014) had used this approach effectively in her own research. Morriss’ approach was to look at the natural history of the developing research across its duration; my perspective is more broadly about a reflexive approach to research, and I have used this more broadly to emphasise the significance of my ‘pre-history’.

My AMHP Self

I qualified as an ASW over twenty years ago and continue to practice as an AMHP. I have always been alarmed and intrigued in equal measure that different AMHPs can arrive at different decisions about the removal of the liberty of the same person. I have observed a range of different styles of practice and decision-making processes and have often struggled with those that are not observant of the power in the room, and the ways in which this manifests in language and attitude. This became an increasingly regular aspect of my reflections and the micro-analysis of social interaction seemed to me to be a valuable way of understanding what was happening. Of course, practising as an AMHP also makes me a colleague to AMHPs, some of whom were involved in the research, and this inevitably impacted on the issue of insider/outsider conflicts.

My AMHP Educator Self

I have taught many of the AMHPs in the Local Authority area where this research took place and have also delivered post-qualifying training to many of these same qualified AMHPs. I can see now that I was unprepared for the research participants seeing me through this 'lens' as it was not how I saw myself in the research setting. Additionally, given my interest in decision-making, power and interpersonal dynamics (as well as the application of empowering principles) I had actually been motivated to begin a research project due to the lack of research, the invisibility of the role and the lack of training materials in the area to the extent that one day, out of frustration, I declared I would 'do something myself, then' which was possibly an unconventional rationale (and certainly naïve) but I later learned that this was not unique (Hammersley, 1993).

My AMHP Researcher Self: Insider and Outsider

As indicated above, I had existing relationships with some participants who knew me as a colleague, an educator and a trainer. I found it difficult at times to reconcile their view of me with how I saw myself. I had to be disciplined in my research role and this was highlighted, as discussed elsewhere, in what came to be known in my research diary as 'the one that went wrong'. I had read around the idea of the insider/outsider phenomena and realised that, with the aid of deliberate reflection and engagement, this can reveal itself in tangible ways.

My Student Self

At times I have found it difficult having a student status which has reduced the level of autonomy that I have in other aspects of my life. At an early stage of my experience, at my first Research Ethics Committee (REC) the advice from the REC that I needed to take 'baby steps' reinforced my existing worries that this was going to be an infantilising experience. I wondered if the committee had factored in my lack of status and experience, or my being an outsider or fledgling, in a culture or community of research. This perhaps is reasonable, in terms of my lack of research experience, but is nevertheless challenging given what I believed were good intentions. My diary notes highlight frustration, perhaps a sense of indignation, and a perception that my professional integrity was under-developed or being questioned. In researching this area I was comforted and concerned in equal measure by Mewburn's (2016) suggestion that 'just because you are a student again, it doesn't mean you are a child', whilst pointing to the fact that over fifty per cent of research students have come from the workplace back to study. She also reflected on the significance of gender at this point and questioned whether a problematic deficit model – assuming the student doesn't have any prior knowledge, or agency – prevails.

My Policy-Maker Self

As the research project developed, I was becoming increasingly involved with policy making and national workforce developments through various roles with the national AMHP Leads Network (where I am a co-opted member through my AMHP Research Group and as the universities' representative), a national policy steering group led by the Department of Health and Social Care (as the Higher Education Institution (HEI) and AMHP education representative) and with Social Work England (where I am an Education and Quality Inspector for AMHP programmes). Throughout the duration of the research, I have undertaken presentations at a national level much of which was based on my emerging research findings which has helped me maintain motivation, especially during challenging periods. I believe this cross pollination between my research and my involvement with policy development has helped me toward completion as it has become part of my professional identity.

Overall, my experience has been a complex interaction between practice, fieldwork, teaching, training, policy development and my personal and political interests in the field of study. I had to acknowledge and assimilate this before I could move on to the next stage of the research with the clarity I desired. Certainly, as a researcher I am less experienced, but as a person with a depth of practice experience, along with theoretical and educational experience, I found this juxtaposition difficult to reconcile. As part of my developing reflexive approach, I continued to reflect on and to deliberately engage with this conflict. My diary notes, and my reflections throughout, highlighted the ways in which I moved between being student, researcher, 'rescuer', naïve enquirer, friend and adversary (amongst others).

Theoretical influences

A main focus for this research is on the ways in which AMHPs' knowledge is constructed and developed. I wanted to understand how the AMHP makes meaning (within both a systemic and an individual, relational context) and to explore the processes that are part of their decision-making. I aimed to develop and deepen my understanding of the assessment process (and its professional and organisational contexts) as a whole with particular focus on the AMHPs impact within that whole.

Ontology and Epistemology - Social Constructionism

Ontological assumptions are about the nature of reality, of existence and of the nature of things. These then give rise to epistemological assumptions about *how* we can know, *what* we can know and the ways of researching the nature of reality or the relationship between the inquirer and the known (Cohen et al., 2003). These, in turn, are then related to the instrumentation or methods of data collection (Hitchcock and Hughes, 1995) and, further, to axiology (the values and beliefs we hold) which is key in understanding how we view our world and what is deemed valuable (Lyons and Coyle, 2021). The net that contains the researcher's epistemological, ontological, and methodological premises may be seen as their 'basic set of beliefs that guides action' (Guba, 1990, p.17).

My epistemological position here is formed from constructionism which, as a research paradigm, challenges the existence of an objective reality (Atkinson et al., 2007). The world is not seen to exist independently of the researcher but, rather, the researcher is involved in the collection, construction and attribution of meaning to the setting (Latour and Woolgar, 1986). Social constructionism shares its orientation (the terms are sometimes used interchangeably) with constructivist and interpretivism paradigms (Blumer, 1954).

Social constructionism does not deny that there is a 'real world out there' but it does not concern itself with the nature or essence of things (ontology) instead choosing to focus on how we come to know about the world (epistemology) (Taylor and White 2000). From this perspective social constructionism is

> ontologically mute [and] whatever is, simply is … [however] once we attempt to articulate 'what there is' … we enter the world of discourse (Gergen, 1994 p.72).

Within this paradigm, social reality is constructed, social stability happens through social order and, when people interact with a social system, they are creating concepts and mental representations of their actions (Berger and Luckmann, 1966). There are no objective facts about the world and ourselves within it. Rather, the categories we use to interpret the world are built up through social processes, in particular linguistic interactions, so there is nothing fixed about them: they are the products of particular cultural and historical contexts. This constitutes a relativist stance whereby 'reality' is dependent on the ways we come to know it. Research focus is on the ways we construct this reality within these particular social contexts, and the implications they hold for human experience and social practice (Willig, 2013; Lyons and Coyle, 2021 p.16).

Social constructionism may be referred to as a movement, a position, a theory, a theoretical orientation, approach or series of positions which, after Berger and Luckmann (1966) has been influenced, modified and refined by other movements including ethnomethodology, social studies of science, feminism, post structuralism, narrative philosophy and psychology, post-foundational philosophy and post-positivist philosophy of science (Burr, 1995; Galbin, 2014). It is often conflated with postmodernism, a yet more ambiguous a label (Galbin, 2014). Within this study, my position is consistent with that of Berger and Luckmann (1966) and I approach it as I way of acknowledging all voices – including neglected or minoritized accounts of the world.

To understand the world one must interpret and construct meaning. Research aims are therefore to understand the complex view of the world from the point of view of those who live it, their emic point of view, and to understand their definition of particular situations at particular times and in particular places, informed by their history, language and action (Schwandt, 1994 p.222). Everyday actors produce orderly, recognisable representations of their social worlds and of interest are the interactions, discourses and ways in which they produce their social reality. The interest is in the ordinary procedures and practical activities that people use to make their experiences sensible, understandable, accountable and orderly. Inner lives and social worlds are interrelated (Holstein and Gubrium, 2008 p.375).

From this perspective, no knowledge discourses (e.g. medical, social or experiential) have a privileged epistemological status since they are arrived at by similar processes of enquiry and interpretation, shaped by the purposes at hand and the social interests of the person (Bloor, 2007). There is, then, a belief in multiple realities and a commitment to hearing and identifying participants' viewpoints in detail (Speziale et al., 2011).

An advantage of seeing knowledge as situated, local and provisional is that it invites a much more thoroughgoing scrutiny as the multiplicity of discourses are opened up for examination (Taylor and White, 2000). That human experience and people's perceptions are not fixed or predetermined but, rather, are mediated linguistically, historically and culturally (Burr, 2003) makes this perspective conducive to the use of my own chosen methods. The emic approach (or 'insider perspective') takes a 'bottom-up' or 'sense-making' stance (Lett, 1990). Researchers aim to put aside their own assumptions and focus on participants' perspectives (Lett, 1990; Lester and O'Reilly, 2019).

Social constructionist approaches have begun to include a recognition of the micro-level processes involved in the construction of knowledge (Gergen, 1985) where language itself plays a central role in sharing knowledge and developing shared constructs (Zein, 2013). Potter (1996) suggests that accepting the construction of metaphor is productive, since

> if we treat descriptions as constructions and constructive, we can ask how they are put together, what materials are used, what sort of things or events are produced by them, and so on (p.98)

Within my methodological approach generally, including engaging Conversation Analysis as method, I aim to go beyond a description of *what* is going on and address the *how* - how social realities are produced, assembled, and maintained. I aim to explore how things are *brought* into being (Holstein and Gubrium, 2008).

A social constructionist perspective enables discussion and knowledge development that other viewing points (e.g. a strictly legalistic/deterministic perspective) would close down (Taylor and White, 2000 p.25). I am interested in how aspects of interpretation, decisions and power are brought into being in a MHA assessment, and in doing so, I am accepting the position that

> Knowledge is not something people possess somewhere in their heads, but rather, something people do together (Gergen, 1985 p. 270)

Most qualitative research tends to be based on an interpretative approach: the meanings of events, actions and expressions are not taken as 'given' or 'self-evident' but require some kind of contextual interpretation. Most qualitative researchers prefer a relatively 'open' or 'exploratory' research strategy (Blumer, 1969). Constructionist, constructivist and interpretivist perspectives are seen as sensitising concepts (Blumer, 1954) and in that sense they are primarily concerned with matters of knowing and being, rather than representing methods per se (Schwandt, 1994 p.221).

This study is designed to facilitate deeper insight into AMHPs' experiences with, and perspectives on, decision-making, which requires a qualitative methodology. To gather the necessary in-depth information from the AMHPs and to consider the impact of all the surrounding variables upon practice, I wanted to explore questions such as 'what really goes on in MHA assessments and why?', and 'what do participants think and feel about their involvement in them?' The methods needed to capture the mundane and quotidian and to address crucial aspects of communication skills in situations of multiple contingencies suggest that observational studies are well-suited to making practice visible not only to outsiders, but also to the practitioners themselves who may otherwise take them for granted.

The portrayal of the interpretive researcher as 'bricoleur', or someone who produces a bricolage or a pieced-together, emerging, changing set of representations that are fitted to the specifics of a complex situation (Denzin and Lincoln, 1999; Rogers, 2012) is a perspective that can be applied to my own developing research. The emerging construction changes and takes new forms as different tools, methods, and techniques are added (Weinstein and Weinstein, 1991, p.161). As a methodological bricoleur I was involved with different tasks, ranging from interviewing to intensive self-reflection. As a theoretical bricoleur I was constantly using the lens of constructivism and as an interpretive bricoleur I understood that research is an interactive process shaped by my personal history, biography, gender, social class, race and ethnicity as well as those people in the setting. Research of this nature also includes aspects of the political bricoleur, since research findings in this setting have political and policy implications. I aimed to be a narrative bricoleur, recognising that all researchers tell stories about their worlds and these narratives are framed within specific storytelling traditions or paradigms.

Theoretical underpinnings to methods: Ethnography and Conversation Analysis

Ethnography

Ethnography involves field study to understand groups (or societies, cultures, or institutions) usually by having the researcher being with and being accepted into this culture, and aspiring to understand and articulate it (Brewer, 2000; O'Reilly, 2012). It is therefore the study of people's interactions, behaviours and perceptions in natural settings, including groups, teams, organisations and communities (Reeves et al., 2008, 2013). Essentially, ethnography is 'the art and science of describing a group or culture' (Fetterman, 1998, p.1). It allows us to understand people's beliefs and customs that comprise their common sense about their world (Muecke, 1994, pp.189-190). Being ethnographic with people 'in all their strangeness and in their mundane and quotidian flow' is a valuable and valued way of being able to build a qualitative understanding of the 'particulars and generalities' of the subjects (Madden, 2010 p.32). As a means of studying social phenomena and human society, and as typically face-to-face direct research, it values the idea that to know other people the ethnographer must 'do as others do, live with others, eat, work and experience the same daily patterns as others' (Madden, 2010 p.16).

Reflexive ethnographers produce a description of participants' ways of making sense of the world as well as an understanding of their own ways of making sense of the participants' sense-making. In organisations, this means trying to understand how, and in what ways, an organisation (and its membership) makes sense of itself (Neyland, 2008). From an ontological perspective, the written world does not exist independently of the reader's sense-making and, epistemologically, the knowledge claims involve subjective attempts to construct boundaries around sets of 'social' factors and categories (Latour and Woolgar, 1986).

Ethnography attempts to find a relationship between an 'emic' (recognising, accepting and reflecting the insiders' or research participants' point of view and multiple realities) and an 'etic' understanding of human behaviours (echoing the outsiders' or researchers' point of view). This is critical to an understanding of why people think and act in the different ways they do (Madden, 2010; Fetterman, 2010). 'Cultural translation', therefore, relies on ethnographers retaining their own etic perspective (Madden, 2010 p.20). This also, significantly, includes the motivation that originally brought them to the field. It follows from this that a non-judgemental position asks that the ethnographer suspends their personal valuations or, at least guards against the more obvious biases by making them explicit (Fetterman, 2010 p.23).

Conversation Analysis

Conversation Analysis (CA) has developed from the work of Sacks (1967) and Schegloff (1968). Its focus is on a detailed description of conversation that occurs naturally. Patterns and sequences of speech (or 'utterances') are analysed with reference to, for example, turn-taking, the length of pauses, points of overlaps and interruptions and simultaneous talk (Sacks, 1967). It studies the conversational 'manoeuvres' that are embedded within micro moments of talk and embodied social interaction. The Jeffersonian (2004) transcription system, in combination with audio- and video-recordings, enables the inspection of hesitations, hitches, silences, overlaps, tokens, breaths, laughter, prosodic cues, and other accompaniments to speech production (Maynard, 2013 p. 12).

Verbal interactions produce meaningful actions and from this one person interprets the other's meaning. Distinctive aspects of this approach are, firstly, that any utterances (or non-verbal behaviours) are understood to be the performance of social actions and, secondly, these utterances or actions are connected in sequences: what one participant says and does is generated by, and dependent upon, what the other has said and done. CA therefore focuses on these dynamic processes and the building up of connected sequences. These sequences are understood to have stable patterns, in that how one speaker acts can be shown to have recurrent (and, to an extent, predictable) consequences for the others' responses and this shapes the interaction and its outcomes. To capture the characteristics of speech delivery there is an analysis of the naturally occurring interactions from recordings and transcriptions for which the Jeffersonian transcription was developed. Recording is considered an essential part of capturing the richness and complexity of the detail (Sacks et al., 1974, pp. 419-20).

Conversation Analysis has a social constructionist epistemology in the way that it views knowledge as socially situated and produced by the interactants in situ (Psathas, 1995; O'Reilly and Kiyimba, 2015). It represents an emic approach in that it illuminates speakers' own viewpoints and understandings (Taylor, 2001; Bolden and Robinson, 2011) and understandings emerge from speakers' perspectives as part of their naturally occurring activities (Lester and O'Reilly, 2019). It entails a systematic exploration of 'the actor's point of view' as well as the 'doings' they engage in and the analysis, thereby, does not privilege the role of the analyst over the actors (Button and Sharrock, 2016 p.1).

Further, it has been explained as a form of a microsocial constructionist stance in the ways it sees knowledge as constructed in the micro-structured detail of everyday mundane interactions (Gubrium and Hostein, 2008; Lester and O'Reilly, 2019). As such, CA incorporates both method and a theoretical approach (McCabe, 2006).

A theoretical family

Conversation Analysis was developed in the 1960s and its sociological foundations were based on the work of Goffman and Garfinkel (Maynard and Clayman, 2003; Schegloff, 2003). Goffman has been characterised as a 'progenitor' of CA work (Schegloff, 1988, p.91), with his approach being formed from the observation of people interacting in social situations ('the interaction order') where interaction is a 'performance' shaped by the environment and audience and, crucially, social actors follow conventions and norms within conversation (Goffman, 1983).

Garfinkel's (1967) ethnomethodology was a focus on the analysis of 'everyday activities' within social life and this approach has been described as the 'parent enterprise' of CA (McHoul, 2008). Action is orderly and speakers orient to social norms. They are relatively uninterested in the implicit practices and themes through which local order is achieved, but Garfinkel's (1967) well-known 'breaching experiments' (whereby students were encouraged to breach the social norms in their everyday interactions) illustrate the ways in which the unnoticed standard and normative rules become identifiable when breached (Garfinkel, 1967). Similarly, in CA, utterances in conversation are understood by reference to context and assumptions about the developing sequence of conversation and Schegloff's (1968) early work highlighted examples where the 'distribution rule' for telephone conversation is that 'answerer speaks first' to avoid violations.

The interest was, therefore, to study how people make sense of and describe the social facts, norms and order (Garfinkel, 2002) and the focus was on understanding participants' understandings of the 'indigenous', 'endogenous' or 'lived order' (Heritage, 1984) or just these people, at just this time, at just this place, doing just this – the 'justs' of everyday structures of everyday actions that are social in origin (Garfinkel, 1974). This order is contingent and socially structured and ethnomethodology became the study of the knowledge and practices – the 'methods' - deployed by ordinary actors in their everyday lives (Garfinkel, 1974). CA is a 'fusion' of Goffman's and Garfinkel's approaches of devising an empirical method aimed at exploring how people produce order locally and in situated ways and how they coordinate and accomplish activities in real interactions (McCabe, 2006; Lester and O'Reilly, 2019 p.10). CA is similarly concerned with the ordinary, the mundane, and the everyday social world (Schegloff, 1992) and Sacks' (1984) in 'On Doing Being Ordinary' highlights the ways in which the ordinariness of the world is an achievement of members' concerted practices (Maynard, 2013).

CA is developed from the idea that understanding in action is produced and owned by the participants-in-interaction and that understanding is generated as part of this interaction. For example, accepting an invitation is a second speaker's way of indicating that s/he understood the prior social action to be an invitation (Atkinson and Heritage, 1984). The focus is on the primacy of participants', rather than analysts', understandings and no matter what analysts' understandings of the situation may be, participants will conduct themselves on the basis of their own understandings (Garfinkel, 1967). CA's first principle, that there is order at all points in interaction, is consistent with Garfinkel's view of people as rational actors who make active decisions rather than being passive 'dopes' and the concept of rational design in interaction (talk is systematically organized, deeply ordered, and methodic) is key (Schegloff and Sacks, 1973).

Ethnography

A further 'family resemblance' between CA and ethnography has been noted since ethnography, too, is interpretive and concerned with the lifeworld and viewing point of the social actor (hence 'ethno-') (Pollner and Emerson, 2011). The focus on the ordinary, mundane, everyday world is consistent with Goffman's (1964) 'Ethnography of Communication' in which he discusses the relevance of 'the greasy parts of speech' as a way of understanding the 'human and material settings' in which both talk and gesture occur.

Sacks' attraction to ethnography arose from his interest in the 'this and that' of everyday life, but his disaffection and distancing arose from ethnographers' failure to show the data upon which they based their reports from the field and a failure to show 'how that's so' (Sacks, 1992 p.389-90). Conversation analysts therefore question whether conventional ethnographers have a systematic enough way of connecting social structure to talk (Maynard, 2011), where recordings and or applied CA could enrich this (Duneier and Molotch, 1999, p. 1272). In this sense traditional ethnography influences CA in a bivalent way – it provides reports from the field about interaction but has gaps in that reportage that CA could fill by consideration of actual instances. Within this context, CA's scrutiny of recordings and detailed transcripts is seen as an intense kind of observation (Maynard, 2011). However, ethnographers, with their more expansive approach sometimes criticise CA for its almost exclusive use of recorded interactions, eschewal of field methods and willed neglect of social structure, suggesting that Conversation Analysts needs to also appreciate the provenance of the data (Maynard, 2011).

Applied Conversation Analysis: A reconciliation

'Mundane' or 'ordinary' conversations represent everyday speech and they are not confined to, or in a context of, any specialised setting or specific tasks (Heritage, 2005). Institutional talk, however, takes place in institutional settings and it deals with institutional tasks (Lester and O'Reilly, 2019). Applied Conversation Analysis is a specific type of CA where the deliberate focus is on interactions in which clear institutional tasks are being pursued by interactants who occupy institutional roles, such as doctor and patient (Antaki, 2011) and these task-based social roles are primary. 'Institutional talk' examines the organisation and the ways in which conversation is inflected in the context of these tasks and the social roles associated with them – essentially, how these institutions and identities are 'talked into being' (Heritage, 2007, p.290) or how participants 'do being in that setting' (Schegloff, 1991, pp. 60-61). The interest is in the ways in which 'institutional realities are evoked, manipulated and even transformed in interaction' (Heritage, 1997 p.162).

Antaki (2011) stresses the need for an ethnographic background in CA research because it is crucial in understanding local histories and everyday arrangements of particular agencies and cultures. Indeed, for some CA studies the communication would be unintelligible without a background context of the law, policy or role. Ethnography has the ability to 'flow back' into 'basic' CA and join up with the stream of multi-modal work providing a situated kind of analysis (Antaki, 2011 p.9). So, whilst CA studies do not rely on ethnographic knowledge, analysis of some institutional settings may require contextual knowledge in order to make sense of distinct realms (Moerman, 1998; Arminen, 2005). An unambiguous observation is made by Moerman (1998), an ethnographer, who described a methodological culture shock when faced with CA and its abstract structures and processes of human conversation that seem bloodless and impersonal in the way it neglects the nuances of humans' lived experiences (p.xi).

Lastly, and of significance here, Garfinkel (1964) spoke of the need for the researcher to acquire familiarity with the background knowledge and practices under study as they are self-organising ensembles of local practices whose ways and workings are only accessible through a competent researchers' in-depth experience and familiarity. To be able to identify and understand the distinctive features of the particular field, and to actively participate, they must be 'vulgarly competent' in the local production and have a reflexively natural accountability of the order they are 'studying' (Garfinkel and Wieder, 1992 p.182). In this way, my pre-history served a vital purpose.

Shared Decision-Making

Shared Decision-Making (SDM), as discussed in Chapter One, represents a 'paradigm shift' in the way it is understood to advocate for a person's autonomy and respect for preferences (Ubel 2012; Ubel et al., 2017). This approach also underpins the statutory Empowerment and Involvement principle in MHA assessments. I aimed to explore, using various methods, how and to what extent, if any, service users and AMHPs communicate understanding (and preferences) to one another in MHA assessments.

In mental health settings, evidence suggests that professionals have difficulties predicting what the person's priorities are and that professionals' preferences tend to dominate with decisions often being made without any negotiation (Elwyn et al., 2017). Further, professionals often use inaccessible language and service users report being 'seen but not heard' (Johansson and Lundmann, 2002). Finally, clinicians may not automatically enable participation but, instead, intuitively 'feel' if a person wants to be involved or not (Goossensen et al., 2007).

Shared Decision-Making and Power

A climate of interpersonal non-dominance is sometimes assumed to be implicit and, certainly, an ideal clinical encounter would involve partnership between the service users and clinicians (Charles et al., 1997). Arguably, authentic SDM should be underpinned by 'equipoise', an equally poised or balanced context for decision-making (Gwynn and Elwyn, 1999), and yet there are inevitable power asymmetries, particularly with a MHA assessment scenario with its potential for the AMHP (along with their colleagues) to deprive people of their liberty. This is related to perceptions of autonomy.

Shared Decision-Making and Autonomy

An essential feature of SDM is 'patient empowerment', a concept equated with autonomy promotion (Sandman and Munthe, 2010). However, it is unclear how this applies in practice. It may be supported by building good relationships (Elwyn et al 2012), or that SDM

> respects patient autonomy by involving patients in their health care choices without forcing them to feel like they are making the decision by themselves (Ubel et al., 2017 p.3)

Some understand autonomy in terms of an individual's properties or capacity to competently reflect on their values, desires and motives, to make decisions based on these values, desires and motives and to have their value and preference-based choices respected (Kasper et al., 2012). What seems to be important here is that SDM must be seen as a process and that there is a need for a more value-oriented, relational conception of autonomy which emphasises the interpersonal and relational dimensions, including complex power relations which affect service users' autonomy (Donchin, 2001).

Shared Decision-Making and Communication

Kasper et al (2012) consider SDM's 'essentials' in terms of its epistemology. Some SDM approaches appear to be represented as merely the transmitting of information or knowledge from sender to recipient by linear transfer. The information does not change during this transfer and it is received by the hearer in the same form and as such interferences and biases do not occur. Yet people make decisions through the creation of an internal, mental representation and it is *this* which is evaluated to reach a decision (and not the information originally provided). Information and reality construction in this context are self-organising (and therefore not instructable) and so the ‘exchange of information’ is in itself a form of ‘sense construction’ whereby rather than just being a vehicle, the act of communication itself is the information (Kasper et al., 2012).

This approach underpins my own research questions and methodology, whereby I am interested in communication, as well as SDM, as interpersonal micro-processes, within which different parties respond to each other, rather than a meso-process which would fail to acknowledge aspects of power and interpretations of autonomy. Interpersonal relationships and interactions, as an important criterion of SDM, are often neglected (Vogel et al., 2021) and I was interested to further understanding this aspect of communication within MHA assessments.

Research Ethics in Mental Health Settings

Seeking ethical approval for research of this nature created a variety of considerations and discussions. It also proved to underline practitioners’ primary concerns during service briefings and recruitment events.

Early in the project some, including my supervision team at the time, expressed limited optimism regarding a successful outcome from a Research Ethics Committee (REC) given the lack of precedent for this type of research. Interestingly, when I consulted with groups of service users and individuals who had experience of being assessed and detained they all supported the idea. Contrary to my expectations, rather than being concerned that audio-recording the assessment might be intrusive, compromising or might interfere with a person’s experience of paranoia, all thought that this would actually serve as a protective function with one or two telling me that they had, in fact, covertly recorded assessments to get the ‘evidence on tape’ on their mobile phones. This introduced an interesting ethical dilemma I had not planned for, and it also made me slightly shift my own position on this from slightly apologetic (with questions around exploitation) to one of increasing confidence. I noticed, from my research diary, that I had started to reflect more widely on ethics in a broad sense, rather than as something that is administrative and processual. I had started to think more deeply about my personal and professional ethics, as well as research ethics, and I noted ebbing and flowing confidence around this, something that stayed with me (and arguably deepened) throughout the project. This is not surprising as the ways in which AMHPs (including myself) wrestle with the conflict of the paternalism of the state and with a person’s self-determination, empowerment and involvement is a fundamental focus of my research.

I had been struck by hearing the opinions of eminent thinkers in the field such as George Szmuckler who, as part of a conference on statutory mental health work, expressed astonishment that the area of MHA assessments and decision-making continue to be 'cloak and dagger' as they took place, literally and metaphorically, behind closed doors. Indeed, as outlined earlier, they are undertaken by professionals away from public gaze and without public scrutiny, despite the serious implications for personal liberty (Bean, 1980; Sheppard 1993). Indeed, it was precisely the communication therein that I wanted to explore and open up for scrutiny.

Professional ethics

Within mental health settings there are ideas about dangerousness versus medical necessity, rights versus obligations and autonomy versus paternalism which are informed by underlying value judgments (Chodoff, 1984). Professions are founded on ethical and moral principles that guide practitioners' decision-making and conduct (Parker and Hope, 2000). Medical or healthcare ethics contain principles that have significance for many situations in biomedicine and biomedical research (Kessel, 1998) and are often interpreted with reference to the four principles stemming from the Hippocratic Oath:

1. Respect for autonomy: personal autonomy is an extension of individual self-governance, extending to the freedom from controlling interferences. It includes respect for service users' right to self-determination in matters of their own health and life.
2. Non-maleficence: captured in the common maxim *primum non nocere*, or 'above all first do no harm'. One therefore ought not to inflict evil or harm (non-infliction).
3. Beneficence: doing what is good and useful to the individual and further, one *ought* to prevent or remove evil or harm and one *ought* to do and promote good.
4. Justice: adhering to what is just and respecting justice.

(Beauchamp and Childress, 1994; Kessel, 1998).

Respect for autonomy means that research participation is voluntary and based on fully informed consent, including the right to withdraw at any point. The principles of beneficence and non-maleficence require the researcher to produce recognisable benefit for both the individual participants as well as the wider community and, further, that it should cause no harm. Importantly, the principle of justice entails a commitment to the research burdens and benefits being shared equally throughout populations and societies – which arguably means that no individuals or groups should be excluded from the opportunity to take part in research (Pollock, 2012). My own aspirations, and arguably commitment, are aligned both with the prevention of harm and the promotion of 'good' (beneficence) and justice. Increasingly, I came to believe that the ‘*ought to* prevent harm and promote good’ aspect is aligned with the principles of my own research study. I reflected for a while on the relative weighting afforded to these principles within the discussions I was having.

Paternalism in mental healthcare settings

The idea of healthcare decision-making as paternalistic originated in the Hippocratic Oath where the physician (and, today, the nurse or other staff) makes decisions about treatment and care, ostensibly acting in the best interest of the person. Decisions might not involve them, or they may be contrary to their wishes or ignore their perspective, as long as they are benefited. The person is not seen as rational, and paternalism is, therefore, knowingly going against their wishes for the person’s own sake (Sandman and Munthe, 2010). Decisions are made and then simply communicated to the person who, in turn, is expected to comply regardless of whether their preferences have been taken into account (Sandman et al., 2011). This is clearly in conflict with the professional AMHP value-base with its explicit focus on self-determination (HMSO, 2008) as well as the guiding principles to the MHA pertaining to empowerment and involvement (DHSC, 2015a). This is often conflated with perceptions of ‘insight’.

The problem of ‘insight’

‘Insight’ continues to be a primary consideration in the mental health arena, yet its interpretations are variable. People’s rights as citizens are denied, by virtue of a diagnosis of ‘mental illness’, on the presumption that they ‘lack insight’ (Beresford, 2002). Given the complex power asymmetries in most (if not all) encounters, ‘lacking’ insight has a range of implications. Conceptual ambiguities and the absence of measurements of ‘insight’ have profound ethical implications, such as setting unattainable goals for self-knowledge, as well as minimising people’s own self-knowledge (Guidry-Grimes, 2019).

‘Insight’ may be classed as a type of self-knowledge (in that your insight will be different to my insight), but in mental health settings it usually relates to whether the person has the *right type* of awareness or thinking. ‘Insight’ is sometimes considered to be an all-or-nothing, unidimensional phenomenon or it can be described as ‘poor’, ‘fair’, ‘limited’, ‘improving’ – all nonspecific terms reflecting its limited meaning (Casher and Bess, 2012). Treatment or medication ‘concordance’ is implicated (David, 1990) and there is a circularity problem whereby ‘awareness of illness’ is construed as willingness to accept treatment, so only those who are fully compliant are deemed to ‘have’ insight. ‘Poor insight’, perceived as a refusal to acknowledge or agree with ‘symptoms’ and the likely success of treatments, is received negatively by professionals (they are ‘non-concordant’ or ‘non-engaging’) and trust is lost. Consequently, the professional, taking a paternalistic position, takes over the relationship with the service user’s accounts of their own experiences, needs, values and interests being treated as less valid and less credible (Guidry-Grimes, 2019).

Lack of ‘insight’, then, is substantially a ‘judgment of discrepancy between the perspective of a clinician and that of a service user’ (McGorry and McConville, 1999 p. 132). Of further concern, it can also be a form of social acquiescence whereby people are required to accept the predominant cultural norms and theories about what their experiences mean, even when their differing views about their ‘mental state’ and behaviour may arise from their cultural background or alternative interpretations about mental distress. This is also implicated in the evidence of assessment biases and the ways in which privileged ethnic, racial and socioeconomic groups tend to be given higher insight scores (Guidry-Grimes, 2019). Perceptions of poor or partial ‘insight’, and the consequent distrust, can lead to ‘insight’ shortfalls and the problem can become seen as one of recalcitrance (McKeown, 2016; McKeown et al., 2019; Guidry-Grimes, 2019).

However, psychiatric concepts around illness and diagnosis are fallible and, so, it is not necessarily an epistemic failure for a service user to express doubt about their diagnosis or recommended interventions (Guidry-Grimes, 2019). Certainly, when people are required to account for their own experiences in an artificial or unfamiliar clinical framework and language, they are then denied opportunities for sharing what they actually believe and feel, which in turn undermines their position as an equal partner in the therapeutic relationship (Marková and Berrios, 1992).

Knowledge, power and epistemic injustice

Fricker’s (2007) reflection on ‘power and the ethics of knowing’ describes two forms of epistemic injustice, testimonial and hermeneutic, both of which are ubiquitous in mental health services but harmful in the ways in which they diminish or deny people’s capacity as knowers and ultimately undermining their standing as citizens (Lakeman, 2010). Testimonial injustice arises where a person’s ‘mental illness’ undermines their credibility, authority or ability to know and their own testimony is either not believed or not trusted. Prejudice around ‘mental illness’ causes the hearer to minimise the credibility of the speaker’s words such that they are not believed or trusted (Fricker, 2007). This is particularly bound up within notions of capacity (and thereby procedural and social justice), ‘insight’ and judgements around what someone says, and how they make decisions, construe problems and express choices and preferences (Lakeman, 2010). The second type of injustice, hermeneutic injustice, is apparent when a person interprets their own experience from a frame of reference of their being part of a stigmatised and vulnerable group. They may, for example, hear voices but have internalised social stereotypes that unusual experiences such as this are wholly negative which results in feelings of shame and distance even where the voices might not be malevolent. This prejudice serves to prevent them from making good sense of an experience (Fricker, 2007; Lakeman, 2010).

This is problematic in mental health services, and it also means that this same group of people (i.e those for whom trust and knowing is diminished) are potentially excluded from research. The presence of service users during my research (specifically the audio-recording which allows for a fine-grained Conversation Analytic approach) was intended to enable me to consider the subtle ways in which empowerment and involvement operates (or is undermined), the ways in which people may or may not be invited to share their perspective, are excluded (in terms of being closed down or talked-over), or are being required to adopt a clinical perspective to thereby 'prove' insight in order to avoid detention. Arguably, a sharper focus on what happens within interpersonal encounters between AMHPs and service users will illuminate poor practices that currently remain hidden, and insights into aspects of helpful communications will be highlighted.

Mental Health Ethics and 'vulnerable' groups

The perception of vulnerability among mental health service can lead to restrictions on research and ethical approval (Oeye et al., 2007). Some people, by virtue of their 'symptoms', could be prevented from meaningfully participating in the consent process (Osborn and Fulford, 2003). Psychiatry's history, the conceptualisations of 'illness' and political and social developments around this combine to raise specific questions for research ethics (Buffardi, 2013). Radden (2014) believes that the uniqueness of psychiatry requires a set of professional ethics which goes beyond conventional principles of bioethics and captures the distinctive ethical and policy dilemmas around informed consent, treatment refusal, self-harm, involuntary treatment and competence. Certainly, these types of discussions have taken place throughout the project with practitioners.

Distinctive elements arise from the particular characteristics of the service user, including their apparent diminished judgment, where the idea of the individual as an autonomous agent with the capacity to give or withhold informed consent is not consistently applied (Radden, 2014). Yet 'mental illness' itself is conceptually controversial with ongoing fundamental disagreement about its nature and ontological status and, also, over moral and social attitudes towards it

(Szasz, 1961; Foucault, 1965). Fulford (2018) advocates a form of values-based practice *precisely because* of psychiatry's implicit and epistemic ethical complexities.

Interesting discussions frequently took place with practitioners where there were varying opinions around paternalistic positions and those believing that mental health service users have a right to be involved with research. Misplaced overprotection could, in practice, arguably constitute harm where groups are denied the benefits of research, are not given the opportunity to contribute as individuals with choices and opinions and consequently are not given a voice in the development of relevant policies and services (Dingwall, 2008). If the goal of social inquiry is (or should be) to facilitate some sort of improvement then research should be directed towards this kind of goal and values such as social justice could be realised *as part of* the research process, particularly through the ways in which participants are treated. This makes research 'an inherently ethical enterprise' (Clegg and Slife, 2009, p. 36; Mauthner, 2018). This position is one that initially sat with me at an intuitive or professionally-oriented position and it is one which, over time, I was more able to comfortably articulate to myself and others. I also began to see, over time, how this fundamental position underpins my own research questions and my approach was increasingly oriented to ideas of beneficence (and what the research *ought* to do) and justice within both research and professional settings.

Research Ethics

'Research ethics' has been defined as 'the moral principles guiding research, from its inception through to completion and publication of results and beyond' (ESRC, 2010, p. 40) and RECs assume a gatekeeping role in the way they manage research practice by scrutinising research projects. A REC has been defined as 'a multidisciplinary, independent body charged with reviewing research involving human participants to ensure that their dignity, rights and welfare are protected (McAreavey and Muir, 2011). Research in England involving adult (over 16 years) participants who lack the capacity to consent (or withhold their consent) to participate is regulated by the Mental Capacity Act (2005) (MCA) and research in this area must be approved by an 'appropriate body' in the form of an MCA-flagged REC. These include specific Social Care RECs, although any flagged RECs (including those based in healthcare trusts) can consider the application.

As part of the MCA, certain conditions must be met in order to obtain ethical approval for people deemed to lack the capacity to consent. The research must be connected to the 'impairing condition', or its care or treatment, and there must be reasonable grounds for believing that the research could not be carried out effectively if the sample was confined to adults with capacity. The research must also have some chance of benefiting the person who lacks capacity, and the benefit must be in proportion to any burden caused by taking part. The aim of the research must be to provide knowledge about the cause of, or treatment or care of people with, the same impairing condition – or a similar condition. Risks to the participant should be negligible and the research should not be unduly invasive or interfere significantly with participants' freedom of action or privacy (s.31).

According to the Code of Practice for the MCA (Department for Constitutional Affairs, 2007), benefits and burdens of research need to be balanced, where potential benefits could include: developing more effective ways of treating a person or managing their condition; improving the quality of healthcare, social care or other services that they have access to; and, reducing the risk of the person being harmed, excluded or disadvantaged (paras 11.12-11.14). A fundamental premise of my research is that AMHPs use discretion, yet little is known about how this occurs in practice. Further, as the MHA can have disproportionate outcomes (DHSC, 2018) and the potential to exclude, I was aiming to sharpen the focus on understanding whether there are more effective, or fairer, ways of assessing and making decisions by addressing aspects of power and disadvantage and advancing empowerment and involvement. I believed that a case could be made in respect of the benefits of the research and that burdens were minimal.

Obtaining Ethical Approval for My Research: All phases

In order to apply to an MCA-flagged REC, I completed the Integrated Research Application System (IRAS) form and submitted this via the national (England) Health Research Authority (HRA). I outline the final approval details for each phase below[12].

Ethnography

As part of ethical approval, all AMHPs in the service were briefed about the research in writing and as part of a group meeting. They were given specific information on a specific information sheet and those who volunteered to support the MHA observation phase of the work were, on the day, individually approached to give their written consent (based on a re-issuing of the information sheet) for me to work alongside them, observing their practice leading up to and during their MHA assessment, and to be interviewed after this[13].

More generally, where I was present at any AMHP meetings I circulated information sheets and again secured the consent of all who attended. AMHPs provided their written consent to

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[12] Please see Chapter Four for detailed recruitment processes

[13] All information sheets and consent forms can be found in Appendix Three

be participants within my ethnographic observational study, and for the potential for anonymised use of data to be included in a thesis and any other published material.

Mental Health Act Assessments

For AMHPs who had volunteered to support this next phase, I was based alongside them in their central ‘hub’, or within their specific geographical location (e.g. Community Mental Health Team). They were made aware of requests for MHA assessments at the point of referral. As part of ethical approval, and with the Local Authority's agreement that I could consider the service users' background information, as well as anything that is currently known about that person, along with the AMHP I applied inclusion/exclusion criteria and considered any apparent ethical issues to suggest that recruitment would not be indicated. Where deemed appropriate, and with agreement, the AMHP would discuss the research plan with the person. All shared information was dealt with by and with the AMHP (or any other mental health professionals where relevant). In this way, the research protocol observes the Caldicott Principles. I did not store, print or record any personal information and this information was not part of the overall research project.

Once identified, I discussed the research project with the service user, and where they agreed I sought their written consent for me to be present in the room, to observe the AMHP and to audio-record the assessment. Clearly there is a need, and the service user has an absolute right, to understand what the research is about, and I offered an explanation via a written information sheet, as well as a verbal account of this sheet, including the purposes of the research. Some MHA assessments are, by nature, arranged with some urgency and others are planned so that there is more time available. As a matter of principle, however, I allowed as much time as I could without causing any delay to the MHA assessment.

All participants were given the information in the same way. I offered it in as clear a way as possible, advising the service user that I was observing the AMHP (and not them). All participants were given the opportunity to seek any further information, clarification or to ask questions. I aimed to communicate the information in a way that was easiest to understand. The capability of a prospective participant to reach a decision themselves may be enhanced by using accessible language, allowing time to reach decisions, perhaps encouraging discussion with others, providing education about research, responding to questions about the project, being clear about the possible risks of participation as well as potential advantages or benefits, and being clear that nothing is actually required of the service user during the research – it is about my presence.

The information also had my contact and employment details, and I shared photographic ID. It was continually made clear that taking part was entirely voluntary and had no bearing on the outcome of the MHA assessment.

Ethical approval was granted to the effect that if a service user appears to become unwell during the MHA assessment (raising questions around loss of capacity to consent) but there is no concern or distress arising from my presence, I would continue with the research and complete in the usual way. Should the service user become uncomfortable or distressed by my presence I would withdraw from the research at that point. Before using any information, I would wait until the person had regained capacity, and then approach them to discuss what had taken place and to confirm that I had their written consent and to then use the interview as a debrief. I prepared a relevant information sheet (giving information retrospectively and phrased accordingly) and consent form, and I would share this and seek signed consent to continue. If this was not given, the person would be withdrawn from the study.

Where it was also the case (as with two of the assessments I observed) that there were others present in the assessment (doctors or nurses for example), specific information sheets were shared and written consent was obtained from them.

Interviews

Following the observation of the MHA assessment, and having provided written consent, interviews with both AMHPs and service users were carried out. Interviews were audio-recorded and then transcribed following each interview. All participants were informed that codes rather than names and organisational details would be used. Once the interview had been transcribed, the audio-recording was destroyed in keeping with the university's policy.

Interviews: National Project

The interviews for the national research project were initially supported with ethical approval from the University of Central Lancashire's Ethics Committee. Here, I made contact with service users who had lived experience of MHA assessment and detention through national service user networks. I shared information sheets and volunteers were then provided with consent forms. These were signed electronically from email accounts and I reiterated and re-confirmed understanding and consent at the start of the recorded interview.

At the point at which the university endorsed the use of this data to complete my doctoral research I made contact with all interviewees by email, requesting permission to re-analyse the data for the current process and to re-state intentions to publish through a doctoral thesis and, potentially, peer-reviewed journals and conferencing. All supported this request.

Research Benefits and Burdens

I was always mindful of service users' right to privacy, and I attempted to balance this with the benefits of taking part in research. I was at all times careful that the service user saw me as independent, and not part of the MHA or decision-making. Of course it was always possible that there may be impacts on the service users and I retained some vigilance in relation to this.

There may be a burden around asking the service user to consider additional requests at a difficult time, but it may also be the case that it is seen in the spirit of additional reflection and deliberation on the process. I was clear throughout that I would not be asking any questions directly of the service user and that I was not assessing them. I deliberately positioned myself in the room so as not to intimidate or make eye contact where it was not appropriate or may be deemed threatening or intrusive. I made it clear that service users were not under pressure to participate and that my presence has no bearing on the outcome of the assessment or any subsequent care or treatment. It was an ever-present, at times explicit, aim within the protocol and all information and consent forms, that nothing will be done to which any participants appear to object. If any topics led the service user to no longer wish to take part in the research it would have been ended immediately, although this did not happen.

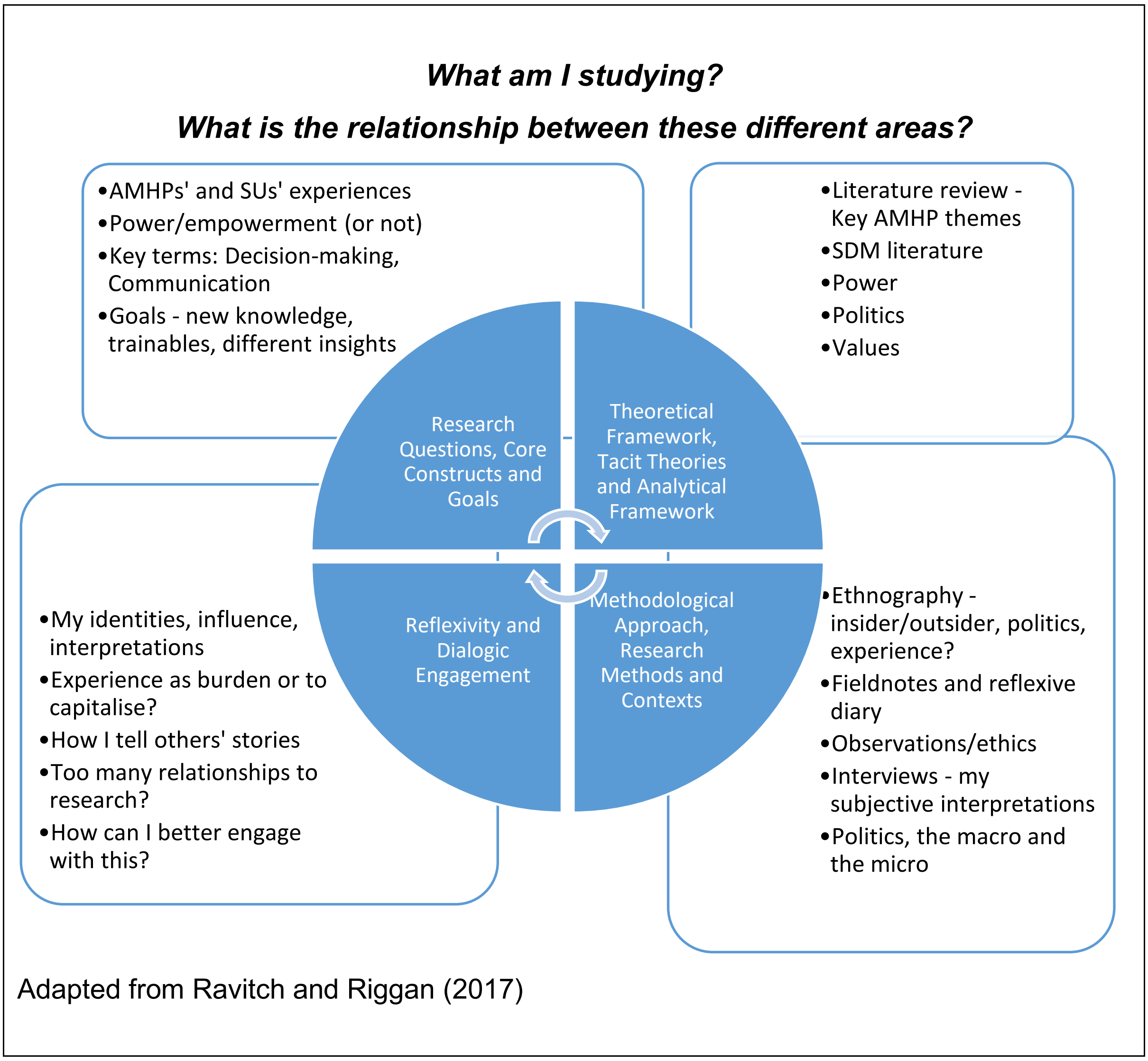
Overall, research suggests that outcomes of MHA assessments are inconsistent which is of great concern. There is very little scrutiny around this. Little is known about how AMHPs communicate with and relate (or not) to service users, and how this may help form how they make their decisions. MHA assessments had so far been largely unexplored and my clear and consistent wish was to aim to provide new information and viewing points, and a sharper focus on this aspect of mental health work, by undertaking research into what happens within these interpersonal encounters between AMHPs and service users, and to consider whether practice is respectful and dignified. As well as understanding what constitutes good practice, this research method can benefit service users by producing knowledge about poor practices that otherwise may remain hidden. I have spoken with service user networks, whose view is that service users have been unnecessarily excluded from research, and that the potential overall benefit of research such as this is that there needs to be greater scrutiny around MHA detentions to avoid any individual being detained under the MHA unless this is absolutely, without question, the only option.

Confidentiality

I discussed participants' personal data information when I was physically in a Local Authority or Healthcare Trust building, but did not save, store, print or make a note of personal details and none of these will have left any building. Consent forms were kept in a locked cabinet in the School of Social Work at UCLan to which only I had access. Audio-recorded material was deleted once transcribed and transcriptions were stored electronically and were always password protected.

Conceptual Framework and aspects of Research Rigour

I started this research with some sort of plan, or conceptual framework, initially to attempt to justify the research, its methodology and its methods. I sketched it out, with it loosely resembling a form of Venn diagram, and as I did this I began to understand how there was a dialogue between the different parts, that a ‘tentative theory’ might emerge and that, fundamentally, I was something of a ‘connective tissue’ between these (Ravitch and Riggan, 2017). Roughly, the map started as below and it continually adapted as I deliberately attended to all the different areas and asked myself how they talked to each other.



Adapted from Ravitch and Riggan (2017)

Figure 3: My Conceptual Framework for Research

One area in particular had more additions and extended notes: my reflexivity. Discussing this with colleagues made me realise that I had made a discernible shift from initially seeing my experience and background as a bias to eliminate, or an affliction, something to exorcise, as something to capitalise on. My diary notes indicated this:

> *X [colleague name] asked me why I wanted to hide or suppress my experience. They asked why I seemed to be uncomfortable with it and suggested that this was something to make good use of … it made me see it as being less problematic and tainted.*

From the start of the research, I had recorded my own expectations, beliefs and assumptions. I was glad I had done this as, when I revisited these sporadically in order to try to keep a conscious awareness and full engagement with them, I was able to confront my concerns head-on. My notes included some interaction with this:

> *Am I seeing what I was expecting to see? Is there another way of looking at this? Would I see things differently with my different heads on? Why is my practice experience more or less relevant (or valuable) than my other identities?*
>
> *AMHPs and service users have their own 'theories' and I'm trying not to neglect these or find myself imposing my own … Anyway, I can't fit this into an existing framework as (apart from my own) there isn't one.*

I had also read, and made reference to this in my notes, that trying to fit any findings into established frameworks can actually serve to deform arguments and the way you frame your research. I found it useful to frame my position in terms of 'borrowing' the data, but deliberately and deliberatively trying to test it not least against my own selves.

I also found it helpful to reflect on what Maynard (2011) referred to above as an appreciation of the 'provenance' of the data and I continued to reflect on this through all phases of data collection in terms of my own interpretations and what I referred to in my notes as 'how this theory got here'. I was acutely conscious throughout of not wanted to assimilate others' experiences to mine, although at times this was referred to a feeling that I was 'tying myself up in knots' around my ever-present sense of liminality. Ultimately, I was continually attempting to maintain a sense of the 'outsider' in my own research. I did recognise from my diary notes, however, that I was becoming more adept, and probably more confident in terms of seeing my own subjectivity as a resource and that this sat comfortably with a methodology based on a social constructionist approach. I did note frequently that I was however telling others' stories based on my own self.

Conclusion

Within this chapter I have outlined my rationale for undertaking this research and acknowledged, as part of a reflexive approach, my own 'pre-history' within this. I felt compelled to act on what I had thought and felt was a gap in my own knowledge and ability to articulate many aspects of AMHP practice to my own trainees and, also, as part of my own reflection and decision-making.

Starting from where I was at the beginning, I could see my various selves within the 'natural history' of my research were informing aspects of my methodology. My practice experience, my role in education and my policy-maker self were consolidated, but they went on to shape my student self and my researcher self in different ways. These in some ways made me focus on axiology (my beliefs and values) as well as the ontological and epistemological positions that shaped the research project iteratively. I had started to reflect on many aspects of the research from the practical (taking field notes is of itself an act of research analysis) to the existential (who am I?). Revisiting my diary notes throughout the project made me realise that this process is not, as I had anticipated, merely a cognitive or practical one: it is emotional and challenging to the self. Early on in the process, a research supervisor advised me that the process was a ‘deconstruction of the ego’ and whilst I still do not know what this means in practice, it does represent an emotional experience for which, as yet, I have no name.

I found the meaning-making, constructionist approach helpful to support the portrayal of the researcher as bricoleur, particularly where the interpretive bricoleur is alert to interpersonal dynamics or where the political bricoleur is cognisant of policy implications. My ‘theoretical family’ helped to support my choice of methods, outlined in the following chapter.

Chapter Four: Research Design and Methods

Introduction

Having set out the connecting theoretical paradigms in the preceding chapter, I now move into the empirical stage of my research history and outline the strategies and methods of inquiry, data collection and analysis that are consistent with these paradigms. These are presented chronologically, in keeping with the ‘natural history’ of my research. I also introduce some of the limitations of the study, not least those unexpected events referred to earlier as my progressing by ‘trial and error’ Silverman (2021) and the reflexive approach I used to try to make sense of this.

In practical terms, the research project is set out in four discrete phases which to some extent overlap in different ways. They are presented in Figure 2 and I will explain each phase in detail.

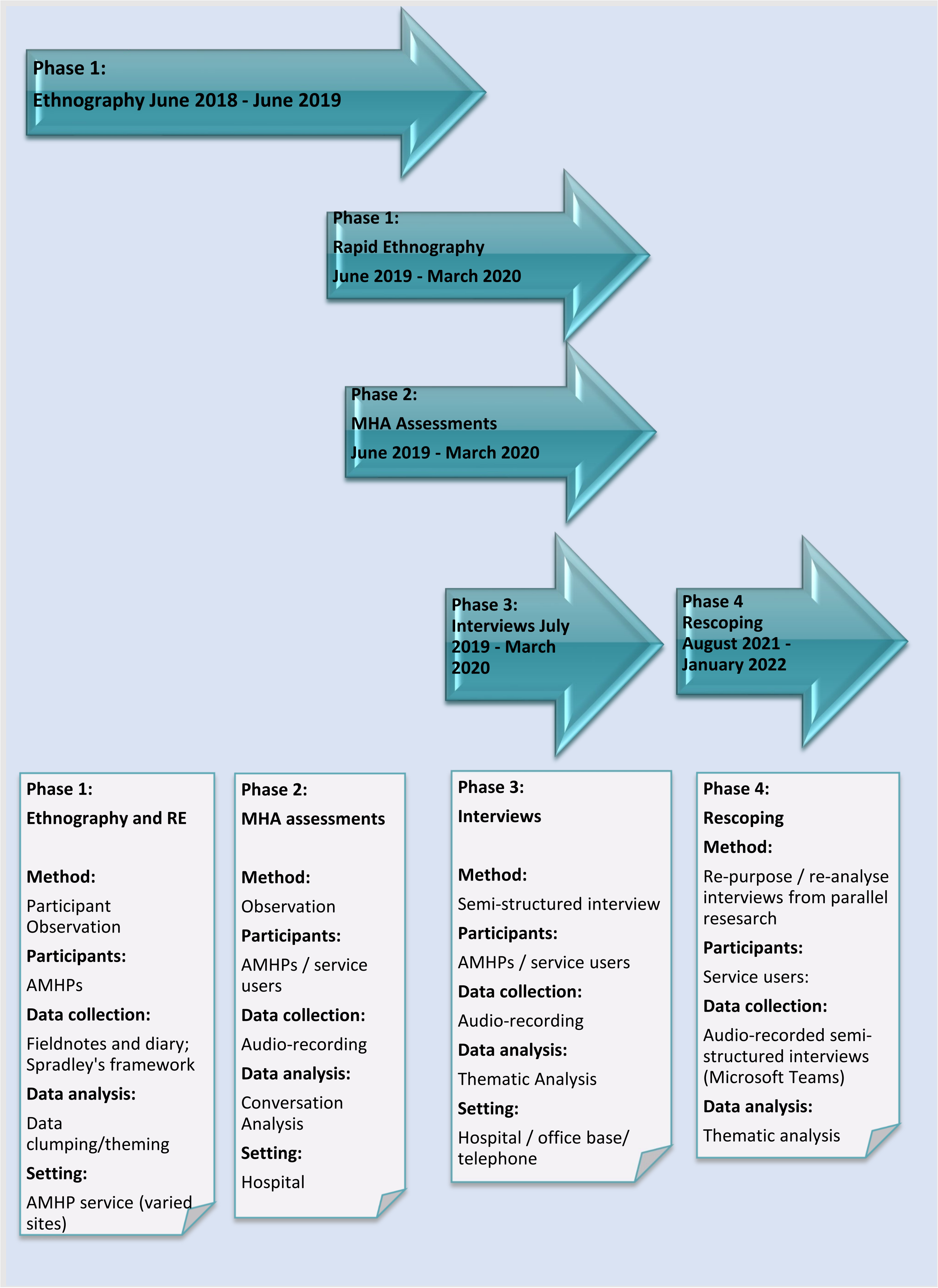


Figure 2 – Phases of Research

Phases 1 to 3: Background, Setting and Contexts

Following ethical approval, I obtained formal approval from Local Authority service managers to go ahead with the research in their area. I was fortunate to find an ally who was interested in the practice knowledge and aspiration for development and who also had access to helpful organisational channels of communication. In some ways they could act as a research 'champion' within the organisation and actively help with publicising the study and encouraging participation (Robinson and Griffiths, 2004).

The research context

The research took place in a Local Authority in the North-West of England with whom I had my own approval to practice, but I was not directly employed by them. I did not have any personal relationships with any of the AMHPs outside AMHP duty, but I may have worked with them previously, taught them when they qualified or possibly delivered post-qualifying CPD training to them. It is a relatively large Local Authority in terms of staff numbers as well as by geographical area and it has a relatively broad and diverse population, as well as a combination of rural and urban areas. Significantly, around six months to a year before I started my research, it had introduced a 'hub and spoke' model of service delivery (introducing full-time and part-time AMHPs) which enabled a more in-depth study of the ways in which these variables might influence AMHPs' practice and decision-making.

Study Advertising

Looking ahead to study recruitment, I attended a county-wide AMHP meeting in May 2018 to deliver a detailed presentation to around forty AMHPs to share information sheets, and provide an overview of the purpose of the study and all that taking part would entail. This was in relation to Phase 1 (Ethnography), Phase 2 (Mental Health Act assessments) and Phase 3 (Interviewing). I was able to answer questions and discuss concerns (which were usually around ethics and the recording of MHA assessments). Following the in-person briefings (and having given AMHPs time to reflect and discuss) I emailed the full AMHP service (around 100 AMHPs in total) with a written overview of the process and I invited volunteers to contact me by return. In all I had fifteen expressions of interest to take part. I had no objections to AMHPs taking part in the ethnographic study and I continued to reiterate the purpose of my presence throughout this phase. From the start, I also undertook to provide a full debrief to the AMHP service once I had completed.

Phase 1: Ethnography

Rationale

My ethnographical study was motivated by a desire to locate and understand some of the themes arising from the ASW and AMHP literature as well as to ‘check in’ with my own assumptions and viewing point given the influence of my pre-history. I aimed to explore these in a tangible setting and develop an applied understanding of themes which had not yet been mined for their deeper meaning and influence on decisions to detain. Initially, the purpose was for me to develop this understanding in order to construct and refine a semi-structured interview schedule that would target this particular population of AMHPs. Contexts from the literature review, whilst mined for their detail, might not pick up on local variables, practises and politics that I might need to be aware of. I was also trying to avoid allowing undue influence from my own practice experiences and interpretations. Quantitative methods such as surveys would be inadequate in unearthing the detail and interpretations of the local cultural and social customs and practices that I was searching for. I was particularly keen to draw on principles of organisational or institutional ethnography which asks questions as to how and in what ways the organisation and its members make sense of itself, and how identities are constructed (Neyland, 2008).

Approach

Having begun a socialisation and familiarisation stage through my advertising and talking to AMHPs and having secured the necessary consent and permissions I spent time, over the space of a year, in the areas where AMHP work took place. I was aware that traditional field studies can involve fieldwork of at least a year’s duration (Naroll and Cohen, 1970; Geertz, 1975) although here the researcher is typically unfamiliar with the cultural setting under study and they enter the setting with a broad, undefined purpose (Morse and Richards, 2002). I had some familiarity with the setting, but I also had a full-time job with the university. I was therefore purposeful in my approach and targeted opportunities that would enable me to experience AMHP settings in their different forms. To understand different viewing points and frames I worked alongside AMHPs in different parts of the service and a year’s duration would mean that I could experience less frequent gatherings such as countywide AMHP meetings.

A summary of my main activities is in outline in Figure 3, below.

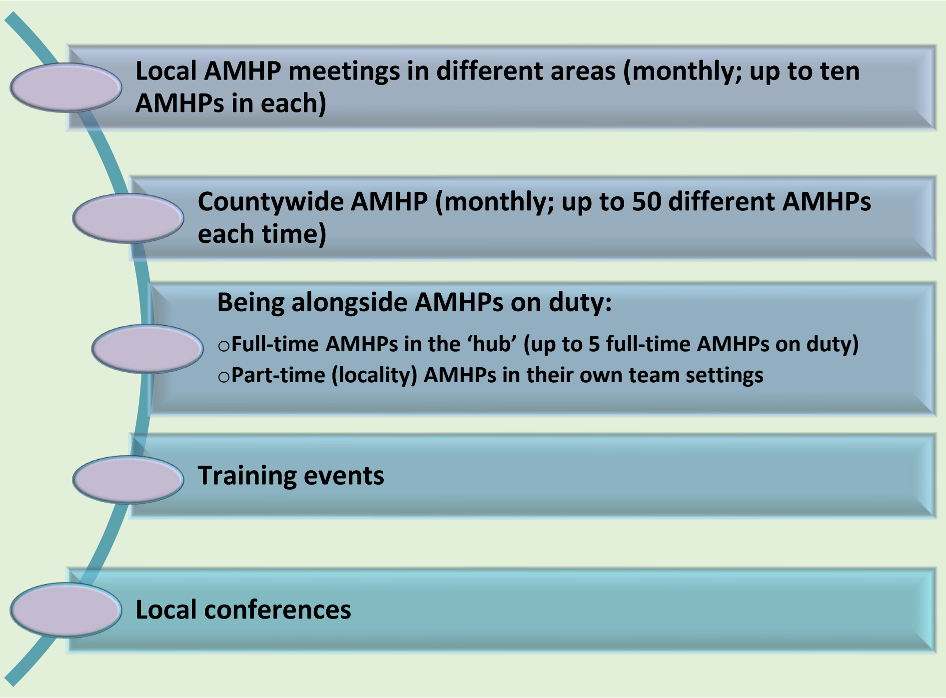


Figure 4: Summary of Ethnographic Activities

I participated in the daily routines of the settings and observed what was going on using a participant observation approach (Simpson and Tuson, 2003; Madden, 2010). This meant aiming to 'get close' to the activities and everyday experiences of AMHPs to enable a deeper immersion in their world and to get a closer understanding of what they experience as meaningful and important (Emerson et al., 1995 p.1).

Data gathering

As I was interested in the quiddity, detail and nuances of the AMHP world from the start I kept detailed fieldnotes, writing down things that appeared to be significant. Initially, I felt as though I was recording everything that happened to capture the 'welter and confusion of the social world' to something that could be reviewed, studied, and reflected upon (Emerson et al., 1995). These notes included my own experiences, thoughts and feelings to enable a robust engagement and a reflexive approach (outlined below). I quickly realised that writing fieldnotes was not simply a matter of writing the 'facts' or 'description for description's sake' (Madden, 2010 p.17), but that it is itself an act of interpretation (Emerson et al., 1995 p.8) with description and analysis coming together.

Fieldnotes are themselves a data set, enabling the researcher to interpret and reinterpret the significance of events and actions through looking at patterns, comparisons and tendencies

(Madden, 2010 p.144). I wrote Emerson et al's (1995, p.146) thought-provoking questions at the front of my notebook in this format:

- **What exactly are people doing?**
- **What are they trying to accomplish?**
- **How, exactly, do they do this?**
- **What specific means and/or strategies do they use?**
- **How do they talk about, characterise, and understand what is going on?**
- **What assumptions are they making?**
- **Why did I include them?**

My handwritten records were reviewed and sense-checked within a day of recording them to aim for currency and authenticity and to prevent the detail being forgotten. Initially they were not well structured, however, over time I began to organise them more systematically using Spradley's (1979) framework for standardising observations. This was developed from Spradley's observation that ethnography requires simultaneous data collection, analysis, and narrative construction which potentially creates a heavy cognitive load. His particular framework is seen as the 'parent' framework from which subsequent variations followed and it was the one that had the most suitable domains for my own notes and specific areas of interest around space (including atmospheres), activities and events that were pertinent to this particular AMHP setting. I adapted this and added to it to include aspects of my own 'selves', including emotions, reactions and, at times, judgements.

Spradley's (1979) Nine observational dimensions:

Space: the physical setting, such as rooms, places, locations, etc.
Actors: the people involved in the study.
Activities: the activities conducted by the actors.
Objects: the physical elements involved in the activities and space, used by the actors.
Acts: the individual actions taken by actors.
Events: context of the acts, actors, and space, such as a meeting or a dinner.
Time: the sequence of events from beginning to end.
Goals: what the actors seek to accomplish in their acts.
Feelings: what emotions the actors express in the events

Data Analysis

To further simplify and prepare for analysis I used Spradley's dimensions as superordinate themes, and then developed sub-themes, with sub-headings as a form of coding and logging which 'allows you to recall the extraordinary complex range of stimuli with which you have been bombarded' (Lofland and Lofland, 1984 p.46). I used Glesne and Peshkin's (1999 p.135) approach whereby through a process of selecting and sorting, I created 'data clumps' (i.e. verbatim examples of speech or my representations of events) which I could place under my sub-themes (e.g. 'Metaphor') and create a broader organisational framework of themes. I was mindful that the act of grouping or 'clumping' is also the process of creating a viewpoint or statement and would therefore follow Carspecken's (1996 pp. 146-153) advice to 'code with analysis in mind' where coding, or theming, should have some relationship with the research questions and literature. Towards the end of the data analysis, as I examined each domain, I might alter or adjust clumps or revisit the data according to newer or different insights that had emerged. I could then select, sort, blend and combine in a way that enabled me to group specific themes and categories (Madison, 2011 p.43).

At times, I found it particularly helpful to take the advice of Emerson et al (1995, p.145) and approach my notes as if they had been written by a stranger in order that I could achieve a sort of emotional distance. Inevitably, however, they are filtered through my own experiences, concerns and interests and I acknowledged this throughout. Existing theories and research literature had sensitised me to certain issues, but an open-minded approach is essential to enable analytic codes and categories to be developed from data itself (Blumer, 1969; Van den Hoonaard, 1997).

As I continued to read the notes, and later the complete set, I could see patterns and tendencies, similarities and differences and the potential for alternative interpretations of actions or talk that I had previously understood in a different way (Madden, 2010 p.144). I continued to evaluate this information until I was satisfied that my themes were as consistent and representative as I could make them. These were all catalogued in a table in the form of headings.[14]

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[14] A summary overview can be seen in Appendix Two of this thesis.

Ethnographical challenges

At times I found that remaining an observer in the midst of absorbing events is itself an achievement and, as I go on to discuss in the following chapters, it is difficult not to be seduced into some form of participation. I noted a feeling, recorded as 'role blurring' on several occasions, and this related to my presence as both insider and outsider in the research. For example, I noted that:

> *I can't always tell whether they [AMHPs] are talking to me as fellow AMHP, colleague, friend or teacher. Does it matter? How does it matter? Why does it matter?*

On more occasions than I anticipated I had to remind myself of my research goals and priorities (Emerson and Pollner, 1988). One example of this, outlined below, was consistently referred to as 'The One That Went Wrong'.

Ethnographical revelations

In many more ways than I had anticipated, there were areas that were not apparent to me until the ethnographic work had begun, and which could not have been revealed using other methods. These became significant areas for data collection in and of themselves. They included the use of language as ways in which AMHPs seemed to manage their work and the very many aspects of professional and organisational identity and conflict. I noticed particular trouble spots or forms of discourse within different settings. In ethnographic research, Marcus (1995) recommends 'following the people' and also 'following the thing'. I did not plan for it but I learned of the importance of location and environment. I had not previously noticed that there are several organisational and individual identities and perspectives within the AMHP service, which Madden (2010) would recommend seeing as a boundaried field-site of its own. Further, the locations (that is, the people within them) did not always work together in ways that the organisation expected, and I wanted to understand this better. I had recorded in my notes that:

> *In some situations they are friends and allies, in others there is some antagonism. I want to know more about what this is about.*

Rapid Ethnography: Phases One and Two intersecting

Phase 2 was intended to solely be a series of observations of AMHPs during MHA assessments. This entailed spending time being alongside the AMHP before, during and after the assessment process. I was with the AMHPs on their literal journeys to assessments and back and at all times I was talking to them and trying to understand what they were thinking and how they were feeling. A similar method was used by Ferguson (2014) to achieve 'close up encounters', where the term 'practice-attached research' was used to explain how the researcher 'sticks to' and observes practitioner-service user encounters. I came to realise that Phase 2 was, in practice, not merely a process of recording and observing assessments but that it was, in fact, also a valuable process that was informing and deepening my ethnographic findings. Although I was in the field far less frequently than in Phase 1, I wanted to stay in touch with the AMHP service in the broadest sense to keep abreast of service developments. A re-routing of the natural history of my research arose from my failure to anticipate the ethnography phase being far more than an emerging interview schedule, in that it became an area of research interest in its own right. Again I felt a sense of lack in its completion and my understanding. It was something I wanted to keep in touch with. I was aware that the project grew in size at this point and have reflected on whether this is part of the observation that I have a particular problem with 'Fear Of Missing Out'[15] but I worried that there were still 'nuggets of gold in the data' which would be 'too hard to mine' (Millen, 2000 p.281) without amending my approach. Mindful of the value of maintaining an ethnographic focus but having already conducted an in-depth ethnography in the area, my solution was to use some principles and practices of a Rapid Ethnography (RE) approach to achieve this.

Rapid Ethnography

Ethnography has changed its meaning as it has developed and it 'has long since slipped out from under the anthropological tent' (Wolcott, 1999 p.42) and as research methods develop, adapt and change their purpose, new forms of ethnographic research have evolved (Knoblauch, 2005). More recently, particularly within social sciences, health and business research, ethnography has become associated with an enhanced, team-based, intensive case work style (Millen, 2000). It is no longer characterised by long-term engagement and, instead, it involves shorter 'intensive excursions' into people's lives (Pink and Morgan, 2013).

A rapid (or 'focused') ethnography can deal with a specific context, and it is conducted within a sub-cultural group with which the researcher is familiar (Morse and Richards, 2002; Roper and Knoblauch, 2005). It is especially relevant when conducting applied social research in fragmented and specialised fields of study (Knoblauch, 2005) as well as having pragmatic value where time is constrained and a classical time rich, lengthy, immersive ethnography is impossible to achieve (Bentley et al., 1988; Johnson and Vindrola-Padros, 2017). It addresses organisational and workplace experiences and cultures (Baines and Cunningham 2011, Handwerker 2001). Rapid ethnographies can inform policy and practice and they have proved

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[15] My 'FOMO' became incorporated in my annual appraisal as something to be managed.

useful in capturing the complexities of healthcare practices and systems since the quick turnaround of findings is conducive to a sector with changing organisational climates and priorities (Vindrola-Padros and Vindrola-Padros, 2018).

The researcher focuses on participants' common behaviours and shared experiences and works from the assumption that they share a cultural perspective (Morse and Richards, 2002; Cruz and Higginbottom, 2013). There can be a sharply focused dialogue between research and theory, so they are theoretically engaged and therefore suited to a range of theoretical, methodological and empirical interests in a work setting. They are theoretical turns towards practice and practical activity, enabling a focused understanding about what people are actually doing (Pink and Morgan, 2013). Targeted, specific research questions are developed, and researchers will 'zoom in' on the important activities to answer these questions. Millen's (2000) metaphoric approach is that of the 'telephoto lens', since well-defined research questions will enable the researcher to have a 'pretty good idea where to aim the camera' and the researcher's observations become 'motivated looking' (Millen, 2000 p.284).

In RE, a typical (and for some, an essential) approach is to have more than one observer in the field at the same time. These observers can include those with different standpoints, for example managers and workers who observe different activities or groups. Their multiple views and analyses of the same event, policy or cultural issues can provide a richer representation and understanding of the situation and discrepancies and gaps in understanding can be noted and resolved. I sought volunteers and three AMHPs consented to take part and agreed to act as ongoing contacts and supporters. They were already clear about the purpose and nature of the study, its ethical issues and the areas that I had refined for ongoing attention.

In RE terms, they became key informants, a role also referred to as field guides, community guides or liminal group members (Millen, 2000; Baines and Cunningham, 2013). Corporate informants, or employees of the organisation, are considered to have field experience, knowledge and insight about the ways in which work is really carried out, or what things really matter, so these 'insiders' were able to support ongoing reflection and enable me to connect my thinking with local concerns and debates through feedback and planned discussions. In this sense I was an 'outsider' with the potential for a different viewing point on the local ways of being. I could ask questions and 'sense-check' my own pre-conceived notions, practices and taken-for-granted assumptions (Rubin and Rubin, 2005; Fetterman, 2010; Baines and Cunningham, 2013). For reasons I go on to discuss, I was particularly keen to work with the ‘troublemakers’ known for their dissenting views who can be used to cross-check information (Beebe, 2001).

These key informants were also able to support me to retain my focus, and to understand where to find interesting and useful pieces of information or areas of tension, thereby reducing the observation time necessary by knowing where (and when) to look. As Millen (2000) suggests, if you want to catch fish, it is nice to know where to find the local fishing spots. Our planned discussions and catch-ups provided opportunities for debrief and feedback from events such as local and county team meetings, referral meetings or, occasionally, MHA assessments. In RE, the entities studied are not necessarily groups, organisations or milieus but rather situations, interactions and activities. There is a ‘focus on the particular’, including social interactions, and they typically analyse structures and patterns of interaction, such as the coordination of work activities, the course of arguments, or meetings (Erickson 1988, p.1083).

Most RE studies combine multiple methods of data collection, with the most common combination being interviews and participant observation (Vindrola-Padros and Vindrola-Padros, 2017). In fact, the days I spent with AMHPs while we waited for assessments were a form of RE ‘activity walkthrough’ (or ‘ride along’) which entailed spending a ‘typical’ day with a practitioner and making extensive field notes from informal conversations and observations (Kluwin et al., 2004). As I did this, along with debriefs and shared reflections with informants I kept up my ongoing data analysis and reflections and kept my empirical insights in dialogue with theory throughout (Pink and Morgan., 2013). This included the ways in which my self, and my ‘pre-history’, impacted on the interpretation of the data. This helped me to understand perceptual differences and various points of agreement and disagreement (Pink and Morgan., 2013) that I could use for discussion. Overall, however, and in keeping with RE, during this stage my focus was sharper, refined around my earlier themes, and my data collection and analysis continued to be concurrent and intertwined. Millen (2000) refers to these activities as ‘time-deepening strategies’ to enable people to achieve ‘higher rates of doing’ (Robinson and Godbey, 1997) which helps to ‘make the most of the field time’ (Millen, 2000; Handwerker, 2001).

I continued to use the same ‘data clumping’ and organisational framework for themes as I had during Phase 1 of the ethnography but added a further colour code to enable me to distinguish and be clear about the source of the information. Sometimes feedback from informants would include rich data such as analogy or metaphor, both of which are purposeful aspects of data gathering in RE (Millen, 2000 p.285). In RE, traditional, open-ended interviews and explorative observations can be replaced with condensed equivalents with a focus on specific propositions and/or issues of interest which have been pre-identified (Baines and Cunningham, 2013) and so we did aim for something of a ‘zoom lens’ in the data gathering. However, the most important aspect was that this approach supports an interpretation of the intersections of social and policy changes that were happening both national and locally, something that RE has been described as being conducive to (Millen, 2000; Handwerker, 2001; Szebehely, 2017). Given the ongoing developments I had a macro-level (national) focus and involvement through my policy work, but I needed a meso-level focus on the particular agency context, and a more micro-level focus on the impacts on different groups of workers providing the basis for a deeper and richer assessment (Baines and Cunningham, 2013).

RE and its critiques

Some critiques of RE focus particularly upon a lack of consistency or critical evaluation of the methods (Beebe, 2001 p. 108). It has also been suggested that calling research methods rapid ‘has been used to justify and legitimize sloppy, biased, rushed, and non-self critical work’ (Chambers 1994, p. 108) or that rapid ethnographies might end up being a ‘quick and dirty’ exercise, unable to capture the wide range of views of actors in the field or analyse changes over time (Vindrola-Padros and Vindrola-Padros, 2017). Criticisms may arise from the image of ethnography continuing to rest on classic anthropological ethnography with researchers being immersed for long periods of time in the field to develop relationships, understand the local context and collect in-depth and rich data over time (Knoblauch, 2005). One suggestion is that these approaches could be re-named ‘focused ethnographies’ to distance the approach from perceptions that they are superficial (Knoblauch, 2005).

Overall, Rapid Ethnography’s timeframes vary with research projects ranging from five days to six months (Vindrola-Padros and Vindrola-Padros, 2017) but there is no general rule about the ‘right amount of time to spend in the field (Roper and Shapira, 2000) and researchers therefore have latitude to determine what works best for their studies. Having undertaken a more traditional ethnography in Phase 1 I thought that the RE elements experienced in Phase 2 added greater depth to the overall ethnographic architecture of the study. Certainly my own experience of RE belies any critique that the approach is superficial, in that the data collection is focused and labour intensive.

Phase 2 – Mental Health Act Assessments

As outcomes of healthcare interventions depend on the quality of interactions between professionals and service users, it is important to explore how professionals' communicative actions have an impact as well as the ways in which patterns of behaviours and actions can be deliberately applied in practice to facilitate involvement and influence outcomes (Drew et al., 2001).

Research in this area has relied on retrospective interview and self-report data so of interest in this study is to understand what actually takes place in a MHA assessment where, to my knowledge, no observational studies have taken place and no research has analysed recorded interactions of assessments for the current purpose. Without recordings, research relies upon summaries, retrospectives or idealisations of what occurred, and the complex details of talk-in-interaction are lost (Toerien and Kitzinger, 2007).

As indicated elsewhere, MHA assessments are unique, involving different participants, constantly changing dynamics and varying outcomes. There are inherent power asymmetries, and little is known about how the Empowerment and Involvement principle and the principles and practices of Shared Decision-Making are brought into being in the conversation. To study this further, I observed and audio-recorded MHA assessments.

I knew, however, that for several reasons around overall ethical considerations and aspects of consent, many of these days would not end with an assessment. Nevertheless, and as outlined above, the time spent in this way would still be valuable and add to findings from Phase 1. I had anticipated that to record ten to fifteen MHA assessments (my original plan) would be a lengthy process and I had allocated a further year to do this.

Recruiting AMHPs: Volunteering

Volunteering was on the basis of current AMHP practice and the willingness to allow me to observe practice including, in Phase 2, to observe and audio-record the MHA assessment (regardless of the decision and outcome) and to be interviewed following this. An inevitable aspect of voluntary participation is a self-selection bias where individuals who consent to be involved may be different to those who do not in ways that are not related to sampling criteria (Costigan and Cox, 2001). In interviews, for example, where self-disclosure may be required there is likely to be a sample containing people who are more confident, open and interested in the topic (Robinson, 2014). For many reasons, not least, ethical ones, the self-selection bias could not be avoided within research such as this, so it needs to be borne in mind when considering findings and their generalisability.

Purposive Sampling

Samples in qualitative research tend to be small in order to achieve depth. Qualitative samples are purposive in that they are selected by virtue of their capacity to provide richly textured information, or ‘information-rich’ cases, relevant to the phenomenon under investigation (Vasileiou et al., 2018). Purposive sampling involves identifying and selecting individuals, or groups of individuals, who are knowledgeable about or experienced with a phenomenon of interest (Cresswell et al., 2011). It is criterion-based and should be consistent with the research questions (Bryman, 2008). The relationship between participant selection and the research question is what makes qualitative methods ‘purposive’ (Collingridge and Gantt, 2008).

Purposive sampling views sampling as a series of strategic choices about with whom and where to conduct my research so that I was able to meet my research objectives. Who a participant is and where they are located is important – they are not interchangeable (Palys, 2008). The ‘who’ and ‘how many’ participants there are will depend on ‘what you want to know, the purpose of the inquiry, what’s at stake, what will be useful and what will have credibility’ (Patton, 1990, p. 184). Based on what is learnt before the research starts and as the research proceeds, researchers are strategic in selecting a limited number of cases towards producing the most information that is usable (Patton, 1990).

A drawback is that this type of sampling may be prone to researcher bias and that I may have been making subjective choices about representation. I tried, in my analyses, to be mindful of individuals’ characteristics and their potential to be significant. As sampling is sequential rather than pre-determined (Curtis et al. 2000, Walsh and Downe, 2006) I aimed to adjust the representation of participants to achieve maximum variation. While many AMHPs’ experiences are common to all, there are also idiosyncrasies and examples of uniqueness. Where possible, I aimed to deliberately select participants to provide the most information-rich data possible.

My aspiration was to find a sample who could provide representation in terms of individual demographics (gender, ethnicity, age etc), professional background (social work and nursing only in this local authority), team base (i.e. whether they were full-time or part-time AMHPs, or whether they covered night time work) and so on. Their specific geographical location was less relevant as the assessments they receive could be spread across the county.

The precise gender breakdown of the local authority was not available, but I had a relatively high number (nine) of male volunteers. This seemed to be in keeping with the national trend (Skills for Care, 2021) whereby there is a higher proportion of male workers in comparison with the social work workforce. According to national data (Skills for Care, 2021) 79% of AMHPs are White and 21% from racialised communities (Black, Asian, mixed or minority ethnic backgrounds) and my sample did not reflect this in that only one volunteer was not within a White category. My volunteers were also all from a social work background and so my purposive sample was not fully representative of the national demographic which is 95% social work, 4% nursing and 1% occupational therapy (Skills for Care, 2021). I did however have representation from both full-time and 'mixed role' AMHPs which enabled access to AMHPs from different backgrounds within the organisation although none were located within the healthcare trust – all were local authority employees. One was relatively newly qualified (one to two years), the remainder had been qualified for a minimum of five years.

Duty Days: The Research Process

Where AMHPs had volunteered, the next stage was for me to join them on their 'duty' days. At the beginning of the day, I would share Participant Information Sheets and obtain written consent for me to work alongside them as a form of practitioner-attached research (Ferguson, 2014). An ideal day would be for me to observe and understand practice experiences in the lead-up to an assessment, to go on to recruit a service user and to observe and audio-record the MHA assessment.

Recruitment – service users and Mental Health Act assessments

As AMHPs, as part of their duty days, received requests for MHA assessments they screened the information to determine the appropriateness of my observing the assessment. They applied inclusion and exclusion criteria and considered apparent ethical issues as well as aspects of capacity to consent.

Inclusion/Exclusion criteria

Service user participants had to be adults (over 18) who were going to be part of a planned MHA assessment. They were people believed to have a mental disorder within the meaning of s.1 of the MHA 1983, limited to functional mental health problems. This meant that those with organic conditions such as dementia, people with significant learning disabilities, people with suspected physical conditions causing confusion, and service users with a primary substance misuse problem were excluded. Participants needed to be English-speaking.

Recruitment process

Where it had been deemed suitable, the AMHP briefed the service user (without my presence) and asked them whether they wanted to consider being involved. All who were asked did agree, so it was a necessary first step for me to seek their consent for me to be present in the room, observing the AMHP and audio-recording the assessment. I offered an explanation via a written information sheet, and by a verbal account of this sheet, which included the purposes of the research. All participants were given the information in the same way, and it was offered in as clear a way as possible advising the person that I was observing the AMHP (and not them) as my interest was in the way decisions are made. All participants were given the opportunity to seek further information, clarification or to ask questions. All consented and I sat in as discreet a position as I could, with an audio-recorder placed between the person and the assessing team. As there were doctors and, on occasion, others in the room, I shared the specific Participant Information Sheets with each individual present and obtained written consent from them too.

Following the assessment, I aimed to return to the service user within two weeks with the intention that the interview would act as a simultaneous debrief and, thereby, be of mutual benefit. I would reiterate the purpose of the research and check that I continued to have consent to use the data from the observation.

MHA assessments can take place in hospital settings (if the person is already an inpatient), in the service user’s own home (a community assessment) or in a designated Place of Safety (usually a room within a Healthcare Trust mental health unit, but not a police cell) where people have been brought for an assessment by police using their powers under s.136 of the Mental Health Act 1983. I aimed to recruit across the different types of MHA assessments and planned to seek out different locations and contexts to represent this range of settings, again aiming for maximum variability. In total (and underpinning Phase 4) I observed three assessments: one had been brought into hospital by police for assessment and was in a designated s.136 suite, one in an Accident and Emergency area and one in a private room in a hospital settings (although this person was not a current inpatient).

Consent and Capacity

For the duration of the research, I did not regard consent as a single event but as an on-going process. As part of my approach (underpinned by ethical approval) a service user might withdraw consent during the course of the research, in which case I would have stopped the research process and destroyed their details. They might also lose capacity to consent during the course of the research and where this had been the case and there was no concern or distress arising from my presence, I planned to continue with the research and complete in the usual way. Neither of those outcomes happened. Before using any information, however, I would have waited until their capacity to consent had been regained and then approach him/her to discuss what had taken place. This would have been part of the follow-up interview and debrief where, in any case, I was revisiting consent.

Ethical approval was on the basis that the AMHP would make the decision around a person's capacity to consent to research so that I would not have influence or the ability to exert undue pressure. This consideration was in accordance with the principles of the Mental Capacity Act (2005) (MCA) and it was based on whether they understood the purpose and nature of the research and what it involved, including any potential benefits, risks or burden.

Principle 2 of the MCA specifies that a person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success. Accordingly, written and verbal information made it clear that the person was entirely free to choose and was under no pressure to take part and that, further, the research would have no bearing on the outcome of the MHA assessment. I took the time to discuss this with them and to answer any questions they had, communicating in a way that was easiest to understand. As well as providing accessible information I made it clear that nothing was actually required of the person during the research, but that I was asking for their permission for me to observe the AMHP in their presence.

Data gathering and analysis

All three MHA assessments were audio-recorded and transcribed using Jefferson's (1986) transcription conventions.[16] Only sections of the recordings where significant events occurred were fully transcribed using the Jeffersonian approach to convey important characteristics of speech delivery, such as pauses, overlap, stress, intonation and pace (see Heritage and Atkinson, 1999).

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[16] See Appendix Four for full key to transcription.

Phase 3: Interviewing

Post-assessment interviews were planned with a dual purpose: to offer both the AMHP and service user a debrief and to enable me to understand these others' perspective, not least as 'providing a context for a person to tell her own story is the best way to capture the complexities of that journey' (Kalathil, 2011 p. 21). Interviews would also support the Conversation Analytic data analysis from the recordings of naturally occurring data. Semi-structured interviews (three with AMHPs and three with service users) took place as quickly as I could arrange them, but at most within three weeks of the assessments taking place as I wanted to capture thoughts, judgements, feelings and the influence of the physical and emotional state of the interviewee whilst it might still be present or available for recall. Each was around one hour in duration, and they were all audio-recorded and transcribed verbatim.

Semi-structured interviews

The semi-structured interviews consisted of broad topic areas and open questions that could be supplemented by probing, to reduce the chances of restricting and suppressing information from participants' perspectives. This type of interview is based on Kvale's (1996) model of the interview as an interchange of views on a topic of mutual interest where human interaction is a critical part of knowledge production and on Dexter's (1970) 'conversation with a purpose' (p. 136).

Within this, an 'interview guide approach' was used to provide a broad framework of topics and issues whilst allowing flexibility and to ensure that interviews remain conversational and situational (Patton, 1900, p.206). My interview guide was based on my themes and understanding from my ethnography and rapid ethnography stages and I had developed some broad questions that could be supplemented by probing techniques (Reissman, 1993). These were 'loose', open-ended questions to reduce the chances of restricting and supressing information.

I applied Kvale's (1996) 'quality criteria' for interviewing which included the use of short interview questions that glean correspondingly long answers and recognising the importance of interpreting, verifying and clarifying answers during the interview itself whilst enabling spontaneity and richness. Given that the topic is broad and, in some areas contentious, I was aware that the fewer questions asked, the more likely I was to elicit stories and deeper meanings from participants. Rather than viewing interview data as static and fixed, and to be 'mined', I considered Kvale's (1996) metaphor of the traveller, with a story to be told upon returning home about the sum of their experiences.

For AMHPs, I was particularly interested in what they were thinking and how they were feeling during the MHA assessment encounter and, more generally, about their duty day. I was interested in their evaluation of their own knowledge and construction of their own decision outcomes. I was also seeking their views on empowerment and involvement as a basic approach as well as a statutory principle.

The purpose of the interview with service users was to glean an overall sense of their experience, to specifically address how far they felt empowered to be involved with the decision-making, and to understand how the language used or the attitude of the assessing AMHP had a bearing on this. As stated earlier, crucially, this interview stage also acted as a debrief and an opportunity to revisit the person's understanding of the purpose of the research and a means of being able to consolidate their consent to take part in the research.

Data analysis: Thematic Analysis

Whilst thematic analysis is not borne of any particular theoretical framework, it is compatible with a methodology founded in constructionism in the ways in which it examines people's experiences, meanings and language (Braun and Clarke, 2006). It is a method for identifying, analysing and reporting patterns (themes) within data. I used Braun and Clarke's (2006) Six Phases of Thematic Analysis, which I have outlined below to illustrate my own engagement with this, as well as to spell out the purpose and spirit of the approach.

My Six Phases of Thematic Analysis

Phase 1: Familiarisation with the Data

Using the audio-recorded verbatim transcripts, and aiming for an understanding with breadth and depth, I read and re-read the transcripts until I knew I had a 'feel' for possible patterns and connections. I took notes and kept an 'ideas' log, flagging up initial thoughts. I returned to these initial 'light bulbs' in later stages to check in with what, in some places, felt like instinct whereas I wanted the analysis to be data-driven. Whilst I had an idea of what I wanted to know, I was aware that all theming processes were my own decisions (or interests) and not objective facts or truths.

Phase 2: Generating initial codes

I worked systematically through the data from printed transcripts, identifying potentially interesting patterns and themes arising from it. At this stage a visual mind-map drawn up on flipchart paper was a useful way of clustering these themes. From there, I produced initial codes. I continued to go back and forth, adding detail, sense-checking the themes and aiming to retain the original contexts of the data sections (at times by checking back in with audio-recordings where prosody and emphasis may have been lost). As recommended by Braun and Clarke (2006) I asked questions of the data (and myself) such as: ‘What does this theme mean?’ ‘What are the assumptions underpinning it?’ ‘What are the implications of this theme?’ ‘What conditions are likely to have given rise to it?’ ‘Why do people talk about this thing in this particular way (as opposed to other ways)?’ and ‘What is the overall story the different themes reveal about the topic?’

Phase 3 Searching for themes

During this phase my flipchart paper-sized ‘mind maps’ became a more elaborate and developed way of framing my data. By this stage, all had been coded, collated and listed. Colours (and the derivative quotes or blocks of text) were literally cut and pasted together in separate documents as I sorted the codes into ‘main’ themes and sub-themes and as I started to deepen the analysis into potential relationships. Braun and Clarke (2006) make the point that thematic analysis is ‘not just a collection of extracts strung together with little or no analytic narrative’ (p.94) nor, indeed, simple paraphrasing of transcript data which became very apparent to me. I started to draft notes for later discussion so that I did not lose sight of the analytic narrative that had started to form as things started to cohere around my research interests and questions.

I acknowledge Braun and Clarke’s (2013) lament that researchers often speak of themes ‘emerging’ as this is a passive account of the process of analysis, and it denies the active role that the researcher plays in identifying patterns and themes, selecting which are of interest, and reporting them to the readers (Taylor and Ussher, 2001). The language of ‘themes emerging’

> can be misinterpreted to mean that themes ‘reside’ in the data, and if we just look hard enough, they will ‘emerge’ like Venus on the half shell. If themes ‘reside’ anywhere, they reside in our heads from our thinking about our data and creating links as we understand them (Ely et al., 1997 pp. 205-6).

Phase 4 Reviewing themes

I began to review my ‘main’ or primary themes and considered the sufficiency of data to support them. At this stage some were collapsed into others to develop clear and consistent patterns and meanings. Where some were isolated or abstract comments they were discarded. I revised my map at this stage to make it more coherent. I then re-read the whole data set to ensure that my themes were representative and retained the original context and meaning (i.e. I had not contrived some in order to make them fit) and giving me a final opportunity to pick up on anything I had not 'seen' earlier.

Around this phase I engaged more meaningfully with Braun and Clarke's (2012) overview of Reflexive Thematic Analysis where there is explicit attention paid to the importance of the analyst's interpretations of patterns of meaning underpinning the theoretical assumptions. Here it is explicitly acknowledged that no two researchers would approach the analysis in exactly the same way and, as such, there should be no expectation that codes or themes interpreted by one researcher may be reproduced by another (Byrne, 2022). It is the researcher who interprets the 'central organising concepts' from the data (Braun and Clarke 2019; Byrne, 2022) and consequently they are not 'facts'.

Phase 5 Defining and Naming the Themes

At this point, satisfied with my themes and 'clusters', I gave them headings and names. This is the 'define and refine' stage to capture the essence of the themes by returning to the data extracts for each theme and organising them into a coherent and internally consistent account with a concise narrative and detailed analysis that is consistent with the research questions. Some of my themes retained sub-themes, as there were subtle but important differences in the data. In preparation for needing to present this orally at different points I took the advice of Braun and Clarke (2006) and considered whether I could describe the scope and content in a couple of sentences and with concise names. Decisions were ultimately about prevalence and frequency (i.e. number of instances and/or number of people who said it) but I also drew on 'golden nuggets', which might be examples of data detailed around a particular theme of interest that represented something powerful but which may be under-attended to in the literature. That said, I needed to avoid 'anecdotalism' where one or a few instances of a phenomenon are reified into a pattern or theme, when it - or they - are actually idiosyncratic (Bryman, 1988) and should not be misrepresented as an overarching theme.

Phase 6 Producing the Report

In preparation for various presentations and for the write-up in my thesis, I decided on the best pieces of evidence I could use to illustrate my themes in a concise and coherent way. I tried to extract the most vivid and powerful means of doing this, whilst also trying to make sure it was consistent with the overall picture, analytic narrative and research questions.

Thematic Analysis: Discussion

In Thematic Analysis, an inductive approach means the themes identified are strongly linked to the data themselves (Patton, 1990). In this approach, if the data has been collected specifically for the research (e.g. via interview or focus group), the themes identified may bear little relation to the specific questions that were asked of the participants. To try to ensure that my analysis remained founded within the data I deliberately did not refer to the interview questions during analysis in order to avoid becoming diverted or overly reductionist. At this stage I viewed these as conversation-starters, and generally discarded them as themes in their own right.

Phase 4: An unexpected global pandemic and a rescoping exercise

I experienced an unexpected chapter in the natural history of my research. I had not anticipated the ‘development through trial and error’ (Silverman, 2021) aspect to be applied as profoundly as it was. In March 2020 I had an emerging set of data and was set to return to complete the fieldwork following an interruption to study. Suddenly, we were faced with a global pandemic. Lockdown, and subsequent rules affecting health and social care settings, meant that eighteen months had passed and my research opportunities were uncertain.

Within the last six months I had, however, led a national research project with the aim of exploring AMHPs’ professional identities and service users’ experiences of AMHPs and MHA assessments (Hemmington et al., 2021). This had included interviews with fourteen people with experience of being assessed and detained and interview topics overlapped considerably with the research aims of this current project. Due to these similarities, I was encouraged to take a pragmatic approach and was given approval to revisit and re-interrogate that data for the purposes of my PhD. I revisited ethical approval and sought the agreement from participants from the national project and I set about repurposing and re-analysing data according to the current themes and research questions.

I was simultaneously relieved to be able to complete, but also disappointed that I might not achieve to the full my original research plan. I was keen to understand and address the study’s limitations where possible. I also experienced a crisis of confidence around how meaningful my data would be. In exploring this, and whether I could satisfy myself (and others) that I had sufficient representative data to be of use, I temporarily diverted, again changing the course of the natural history of my research, and immersed myself in reading around ‘data saturation’.

An unplanned diversion: Data Saturation

‘Data saturation’ is understood to be the point at which no new information, themes or codes ‘emerge’ from data (Braun and Clarke, 2021). Although the concept was created by Glaser and Strauss (1999) as a specific element of constant comparison in Grounded Theory analysis, where sample size is appraised as an element of the ongoing analysis, the concept has been identified as the most commonly used justification for sample size in qualitative research in the health domain (Vasileiou et al. 2018) and even the ‘flagship of validity for qualitative research’ (Constantinou et al., 2017 p.185).

Attempts have been made to operationalise ‘data saturation’ and to provide guidance as to how many interviews are enough to achieve this. Yet judgements such as ‘how many’ data items are enough or when to stop data collection are inescapably subjective and cannot be determined in advance of analysis (Braun and Clarke, 2021). In interview research, the numbers vary dramatically from three to hundreds (Pollio et al., 1997; Braun and Clarke, 2021). Numbers mean little where

> validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher (Patton, 1990 p. 185)

I was encouraged to read that 'playing the numbers game' is often either an attempt to manage discomfort associated with the ambiguity of conducting qualitative research or the need to 'fit' one's research into traditional postpositivist standards (Morrow, 2005). Further, research with social constructionist roots, where knowledge is considered partial, intermediate, and dependent of the situated view of the researcher, does not in any case support the idea that qualitative studies ideally should comprise a 'total' amount of facts (Haraway, 1991; Alvesson and Sköldberg, 2017).

Dey (1999) describes saturation as an 'unfortunate metaphor' (p.257) in that it suggests a completeness of understanding and a determinable, fixed point for stopping data collection. 'Theoretical sufficiency′ more adequately captures the idea that data collection stops when the researcher has reached a sufficient or adequate depth of understanding to build a theory. Nelson (2017) similarly suggested ′conceptual density′ or ′conceptual depth′ to illustrate that theoretical saturation is as much, or even more, about the quality of data collected in terms of richness, depth, diversity and complexity, as it is about the quantity of data collected (Fusch and Ness 2015).

I was mindful of aspects of trustworthiness and authenticity and how far my revised approach could account for what I was intending it to explore. I considered Low's (2019) belief that 'data saturation' is in any case a 'logical fallacy, as there are always new theoretical insights to be made as long as data continues to be collected and analysed' (p. 131). Indeed, my revisiting and re-analysis of the second set of data confirmed this as I had discovered new interpretations according to the research questions here. To satisfy myself, I loosely applied Malterud et al's (2016) concept of 'information power' to evaluate my original sample size and consider whether it was adequate for analysis. Here, the greater the information power a sample holds the lower the number of participants is needed, and vice versa. Several areas have an impact on the information power of the sample and I considered my original, reduced data set against this:

Study aim: I did not need a larger sample as my study aims are relatively boundaried and manageable

Sample specificity: The characteristics of my participants are highly specific (they were all people who have been assessed or detained under the MHA in England) whilst exhibiting some variation within their experiences

Use of established theory and information: This study has a sufficiently specific theoretical and informational background for planning and analysis. New knowledge could be obtained by looking for strategies used by these research participants to negotiate MHA assessments and the communication therein. Empirical studies with small numbers can make a difference if they address and elucidate something crucial to theory

Quality of dialogue: A study with strong and clear communication between researcher and participants requires fewer participants than a study with ambiguous or unfocused dialogues. In a qualitative study, empirical data are co-constructed by complex interaction between researcher and participant, and the analytic value of the empirical data depends on the skills of the interviewer, the articulateness of the participant, and the chemistry between them. Where the researcher holds more than average background knowledge about the topic and interviews are not their first encounter with the subject area, they can enhance the quality and meaning of the dialogue

Analysis strategy: A project using in-depth analysis of narratives or discourse details from a few, selected participants will have a higher level of information power by virtue of its depth: the aim is not to cover the whole range of phenomena, but to present selected patterns relevant for the study aim

Information power is therefore determined on the appropriateness of the data and not the number of participants. Further, a generic requirement for sample size or a requirement for ‘saturation’ is particularly inappropriate with Conversation Analysis where analysts see small data sets of naturally occurring data as more appropriate for their unique mode of inquiry (Potter, 2002; O’Reilly and Parker, 2013). In fact, within CA, Single Case Analysis has been used to understand outcomes of singular events (Whalen et al., 1988) or very specific and idiosyncratic situations (Toerien and Kitzinger, 2007) where ‘the resources of past work on a range of phenomena and organizational domains in talk are brought to bear on a single fragment of talk’ (Schegloff, 1987 p.101). Similarly, Robinson (2007) considers the analysis of single cases and suggests that the integrity of this approach is grounded in the assumption of order-at-all-points and so numbers of cases is not important. In single cases, analysts attempt to demonstrate, from participants’ conduct-in-interaction, that they understand particular features of interaction in particular ways. These data-internal, or emic (vs. etic), understandings are assumed to reflect orderly processes, and thus are used to make claims about rules-based structures of interaction (Schegloff, 1987). That said, Schegloff (1988) notes that although single cases can serve 'to launch a proposal about a practice of action, this proposal is just 'a conjecture' until 'a substantial number of occurrences' (p. 442) can be assembled. If this is the case, I am satisfied that this research exists as a pilot study and suggestions for future research that I may go on to build upon.

Revisiting my Pre-History

Reflexivity

I was aware throughout the research that qualitative enquiry is not a neutral activity, and that I am not neutral, I reflected upon my own experiences and research pre-history and explicitly acknowledged and reflected on these throughout.

Reflexivity recognizes that researchers are inescapably part of the social world that they are researching (Hammersley and Atkinson, 1983 p.14) and as a reflexive researcher I acknowledged how my social, cultural and disciplinary positioning have shaped my narratives (Heapy, 2007). I have my own values, biases and world views, and these are lenses through which I look at and interpret participants' own world view. I acknowledged and, where appropriate, disclosed my own self in my research.

My 'pre-history' inevitably presented me with several viewing points, where I was both within and external to the AMHP world. I recognised that participants behaved in particular ways in my presence (the 'Hawthorne Effect' (Levitt and List, 2011)), not least because of the varying roles that I occupy in relation to their own positions. In the following chapters I outline the observation event that came to be known as 'The One That Went Wrong' due to the blurring of boundaries between my research self, my colleague self, and my educator self and, indeed, as a parent and a rescuer, rather than an observer in the background. Proper ethnographic reflexivity requires that we must not forget that we will always maintain some sense of the 'outsider' despite the fact that we may be, or become, very familiar with the people we choose to observe (Madden, 2010). I tried (and sometimes failed) to reflect on my positionality as 'participant as observer' versus 'observer as participant' (Junker, 1960) to identify any possible biases.

Turner (1982) describes the positioning of the researcher as being one of liminality or the state of being betwixt and between structures or situations - being neither here nor there – neither completely inside nor outside a given situation, structure or mindset. Yet if we embrace the methodologically productive aspects of reflexivity then we can go beyond simply managing reflexivity to a proper engagement with it.

Representing others is always going to be complicated and contentious and I realised that I was always viewing the process through my own idiosyncratic lens. Here, positionality is vital in the way it forces us to acknowledge our own power, privilege, and biases. A reflexive approach means a ‘turning back’ on ourselves to hold ourselves accountable for our own research paradigms and moral responsibility in relation to the representation and interpretation of subjects and their own positions (Davis, 1999). Positionality means ‘being able to recognise and negotiate one’s identities as a researcher … at all stages of the research process’ (Frost and Holt, 2014, p 91).

I noted the ways in which I was interpreting and handling my identities through the way I talked and related to AMHPs at all stages of the research. I noticed that I would sometimes use ‘we’ when interviewing AMHPs about their experiences and identities. I caught myself doing it and I heard it in interview recordings. I asked myself why and reflected on the ways in which it might have impacted on the research process. I wondered if it was an attempt at understanding, allyship, perhaps of befriending, sharing an identity or aiming to be non-threatening. I had spent a lot of time explaining that I was not there to make judgements about their practice and decision-making so perhaps this was on my mind. It might have affected acceptance and engagement, but it might also have suppressed information if it had been interpreted as an organisational ‘we’ or an ‘other’. It might have made people feel less safe and prevented honesty.

Observations and interviews in AMHP settings and practices were the means by which the ‘data’ was collected, interpreted and textually rendered into a version of social reality (Cicourel, 1981; Pollner and Goode, 1990). I was aware that participants participate and actively construct meaning – they are not ‘passive dopes’ (Garfinkel, 1967) whose actions are mechanically determined by social conditions.

There were very many times when my personal values, attitudes, political orientation, social identity, belief system, history and professional views, amongst other things, impacted on the research. I deliberately aimed to be self-referential when taking my notes as I realised that this would support the analytic exercise and illuminate my uncertain position (Macbeth, 2001). Similarly, a process of epistemological reflexivity required me to engage, throughout, with my methodological approach and research questions in order to consider how the theoretical framework supported and informed data production (Lester and O’Reilly, 2019 pp. 68-69).

Having my history (pre-history and the natural history of the research) and being absorbed in ‘AMHP matters’ was both a help and hindrance. I worried that it would undermine the potential for distance and that being immersed meant that I would confirm or ‘find the familiar’ (Madden, 2010 p.3). However, whilst it is important to be sensitive to this potential bias, my assumptions and presuppositions were challenged by early experiences in the field and I continued to undertake a critical rethink of earlier ideas.

Chapter Conclusion

In this chapter I have described the stages of my research and methods as I applied them. The preparatory work to design the study was challenging and this chapter, along with the preceding methodology chapter, have been in construction over some years. For many reasons, I have found them particularly challenging to write, not least due to the potential to fall down too many theoretical ‘rabbit holes’. I was reminded of a quote attributed to Freud:

> Methodologists remind me of people who clean their glasses so thoroughly that they never have time to look through them. (cited in Sterba, 1982)

Phase Four and the various setbacks I experienced from the COVID-19 pandemic meant that a study that, at times, had the potential to already feel unwieldy (perhaps due to my ‘FOMO’) had grown in scope and size as measured by all the different areas outlined in this chapter. Ultimately, however, the important thing was that I arrived at a methodological approach that enabled appropriate data collection as a basis for producing meaningful analysis and trustworthy findings. It is to these I now turn.

Chapter Five: Ethnography Data Analysis and Findings

Introduction

This chapter presents the findings from the first phase of the study: the ethnographical research. The following chapters relate to the MHA assessments and then interviews with the AMHPs involved with the assessments, interviews with the service users who had experienced the assessment and, finally, the reinterrogation of the data from a national project with overlapping research questions. In some respects, Chapters Five, Six and Seven cover the before, during and after of a MHA assessment.

Figure 4 is a general overview to illustrate the approximate time spent on the ethnographic research.

Ethnography	Average no. of occasions	Average no. AMHP participants	Total hours ethnographic study
AMHP Hub	4	24	8
CMHT	1.5	45	9
Shadowing duty AMHP on MHA assessments	1	18	9
Locality Meeting	Av 6	15	6
County Meeting	Av 40	24	8
Training	25	21	3
Total		**147**	**43**

Figure 5: Summary of Time Spent on Ethnographic Research

Figure Five, below, outlines some background demographic data for AMHPs involved with this phase of study:

Approximate number of AMHPs = 37[17]			
LA or Trust employed	Regulated professional background	Full-time/Part-Time AMHP	Gender
32 LA 5 Trust	34 Social Work 3 Nurse	7 Full-time 30 Part-Time	24 Female 13 Male

Figure 6: AMHP participants in ethnographic phase

The ethnographical part of the study had originally been planned to inform an interview schedule and, generally, to enable further understanding of how AMHPs understand and interpret the assessment environment within which they make their decisions. This phase of the study brought into view areas of interest that had not been apparent to me at the start. I realised after two or three months that ethnography, as a method for researching this area, highlighted aspects of the culture and practices of AMHP teams of which I was previously unaware. I had noted in my diary that the setting was a ‘can of worms’ and the words ‘worrying’, ‘concerning’ and ‘troublesome’ appeared and re-appeared.

I spent time, over the space of a year, within different parts of the AMHP service to try to see and feel what was happening in AMHPs’ daily lives. I spent the initial part of my ethnographic research orienting myself to the different parts of the service and familiarising myself with the different styles of, and approaches to, AMHPs’ practice on their duty days. I sat with both full-time and part-time AMHPs in their local teams across the county and I attended local AMHP team meetings and County AMHP meetings, where all AMHPs came together. I also attended other county-wide events, including training events. I observed AMHPs on their duty days (although I did not take part in MHA assessments at this stage).

Using a participant observation role (outlined in Chapter Four of this thesis) I aimed for a deep immersion in AMHPs’ worlds in order to grasp what they experienced as meaningful and important, and I kept systematic notes about what I had observed and learned. There were several themes and patterns that became apparent to me, and I used Spradley’s (1979)[18] framework to systematically organise these as well as adding further dimensions to capture aspects of reflexivity. This approach enabled a systematic and clear process, but it was not

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[17] Information has been presented so as to maintain confidentiality and anonymity.

[18] See Appendix 1 for detail

overly mechanistic. I could establish and follow themes but was also open to the addition of any new ones.

In ethnographic research, Marcus (1995) recommends ‘following the people’ and ‘following the thing’ (p.32) and, in applying this, I learned of the importance of location, environment and of observing where the action took place. I had not been aware that there were quite so many different organisational and individual identities and perspectives within the AMHP service, and I began to understand the numerous ways in which AMHPs formed territorial and professional attachments, identities and narratives. I was interested in how, or whether, this influenced their practice. A diary note summarises this where:

> *Friendships and allyships are not consistent … why is it that there is solidarity in some scenarios but tension in others?*

Setting the scene: the AMHP service

Requests for MHA assessments are received at the full-time AMHP hub, and the co-ordinator allocates assessments to those on duty. Although this is ostensibly solely an administrative function, I learned that it has much greater significance in practice, outlined below.

Full-time AMHPs were based in a central urban AMHP Hub. This comprised a large, open-plan office which also hosted other services, including generic frontline social workers, some police operatives and the Emergency Duty Team (EDT). It was noisy, with tightly packed desks and had been likened to a call centre. There was a large digital ‘countdown clock’ recording the number of social services calls answered, average call time, time taken to answer, flashing lights (blue then quickfire red) when it became ‘critical’, and a two-minute warning to speed up; indicating a prevailing sense of urgency. I noted that I felt under pressure and compelled to action, although I wasn’t sure precisely what action. I noted that:

> *This is stressful, although I don’t know why … It feels slightly anxiety-inducing although nobody has said or done anything! Maybe it’s just the action and movement … never any sense of stillness or space.*

The AMHP team had a hot-desking arrangement, undermining a sense of permanence. I was slightly wary and anxious about sitting in the wrong place, effectively occupying the wrong territory, particularly as it had been remarked that one AMHP had ‘put their scent down’ at one of the desks. I immediately felt marginalised and heard this as a warning, something that made me notice the ‘outsider’ aspects of my position. I was also interested to learn more about the significance of territory and attachments on the behaviours and work of the AMHPs in this environment. I found Spradley's (1980) framework[19] a useful means by which to reflect on what were now ongoing observations and reflections on temporality and space. Overall, I noted this was a team of individuals who once the work was allocated, would quickly leave their base to travel to assessments around the county.

Part-time AMHPs were rostered less frequently. They worked from regular community mental health team bases spread around the county (both urban and rural settings) and their assessments were ideally allocated on a geographical basis. These locality AMHPs had their own assigned desks which were more spaced out within multi-disciplinary settings, often sitting alongside colleagues from different professional backgrounds with whom they might discuss aspects of casework or general teamwork and, as such, they appeared to operate from within a broader organisational framework and identity (rather than just within the confines of their specific role). These spatial dynamics appeared to have a bearing on the way in which they engaged with their organisation and their workplace social relations, where work *team* identity appears to be more noticeable than *organisational* identity when desks are assigned (Millward et al., 2007). I wondered in my notes whether this was allied to the places in which solidarity or tensions were exercised. This included occasional discussions of MHA assessment allocations which acted as a form of peer supervision.

In the AMHP hub, the pace was faster. People were observed to speak more quickly, with greater urgency, at times with irritability (particularly on the telephone) and, on occasion, they would speak over each other. They did not sit down for very long and, at times, their pace was almost at a run. I wondered whether this contributed towards my greater sense of agitation. Language was congruent with a sense of vernacular urgency: for example, 'I haven't got time for this', 'I just crack on', or 'I don't have time to piss about' (the latter being an interesting phrase, in some respects associated with laying scent described above). By way of contrast, part-time AMHPs used language such as 'I need to stop and think about this', 'I won't be rushed', 'we all need to calm down' and 'I just need to press the brake pedal for now'. Whilst I was mindful that the locality team in which I spent more of my time was in a converted barn in a green and leafy, semi-rural location (although this was not the case for all locality team environments) the atmosphere, as well as the demands of the work (from my perspective), were not as visceral.

Across the whole service, the different organisation of part-time and full-time AMHP work and how assessments were allocated impacted the division of labour in terms of relative workloads. In practice, it meant that some AMHPs were undertaking two or three MHA assessments per shift whilst others only undertook one. The impact of this on practice and

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[19] See Appendix 2 for details

decision-making were unclear. This aspect of the ethnography proved invaluable, and it enabled me to add the heading to my notes ‘Assessments fast and slow’. The full-time AMHPs took most of the requests for assessments as they came in whilst part-time AMHPs appeared to be able to decline a second referral. It appeared that AMHPs’ positions in the service, shift duration and, possibly, their fundamental style and approach to the work was affecting their work differently. I was keen to understand if, or how, this served to have an impact on their decision-making. Put simply, full-time AMHPs were undertaking more assessments per day than part-time AMHPs[20] and there were emerging impacts on their ostensible statutory autonomy in contrast with the experiences of organisational autonomy. I asked myself:

> *Who is getting to choose what? Are they in control of the time and reflection they can take on the work or is there a sense of a runaway train for them?*

‘Proper AMHPs’: a battle for cultural capital

In keeping with their professional prerogative, AMHPs generally prized their independence and their work which they see as values-based, rights-based, justice-focused and, as such, a political activity. AMHPs are generally understood to be a political workforce, borne of their professional value base and imperative to challenge and, for many, there is an understanding that activism underpins the work. One AMHP highlighted that the collective noun for AMHPs should be a ‘necessary irritant’, both within a MHA assessment scenario and beyond. This resonates with the description of their being ‘angst-ridden but strangely decisive’ (Brown, 2013) and proneness to act with a ‘higher authority than the law’ (Peay, 2003 p.46).

After a period of around three or four months, I began to notice how AMHPs were organised. The different parts of the AMHP service did not appear to always work together in ways that the organisation expected. I had begun to write about ‘signs of trouble’ and ‘tension sites’ and was trying to see if there were patterns. The more time I spent with the service the more I saw the same AMHPs, but in different settings, which illuminated different aspects of roles, behaviours, cultures and identities. Unexpectedly, I had noticed ways in which the ‘hub’ and localities demarcated the organisational division of labour. For example, the apparently straightforward administrative function of allocating an assessment was interpreted as an exercise of authority and the introduction of a hierarchy of management (I heard ‘they can’t tell me what to do’ or ‘they are not my managers’ more than once). I came to realise that county AMHP meetings (where all the AMHPs came together) were a rich source of

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[20] Some years later, and following further research, this is becoming an area of emerging interest and the national AMHP Leads Network are considering a national service evaluation around the impact of full-time AMHP services on assessments.

information. I was mapping some social relations of power and governing relations within these local contexts and had identified a number of clear protagonists, some of whom appeared to be in charge, but whose identities and relationships sometimes changed according to the context and geographical place. Experienced full time AMHPs accepted responsibility and took charge ('the buck stops with us') when on duty, but these same AMHPs were conciliatory and, at times, deferent in geographical locations that were not their usual base. This area was one in which I noticed that AMHPs could be hawkish or doveish depending on the setting.

When all AMHPs were together, the self-referential terms 'hub-AMHPs' and 'locality-AMHPs' were used, often in a context of sub-division and apparently related to perceptions of relative credibility and power, but these were not sanctioned by the organisation. My notes had questions such as:

> *What exactly are hub- and locality-AMHPs? Is this a formal job role, an attitude, task-based or values-based. Where does it say this? Where does it come from? Is it a shared meaning? It looks like it isn't … does that depend when, where and who?*

AMHPs were struggling with their ostensibly independent role within local, unwritten rules and this became apparent through social and interactional processes. AMHPs appeared to be wrestling with aspects of their core professional identity, and the sub-divisions in the service were making this apparent in very subtle ways.

Communication, meaning and the use of metaphor

The ways in which issues, conflicts and identities come into being through language became apparent and I increasingly focused on what the AMHPs paid attention to and how they conveyed their experiences and emotions. A recurring observation was of their use of metaphor and figurative language to convey these. 'Following the metaphor' enabled me to understand further what was happening, including the ways in which language can change across ethnographic sites (Marcus, 1995). AMHPs used metaphorical language as a means of understanding, articulating and diffusing difficult or controversial subjective experiences. Within county meetings, and more generally, a range of metaphors were used to explain the same experience.

In keeping with perceptions of power and hierarchy I noticed what Lakoff and Johnson (1980) categorise as orientational metaphors, which are ones with an up-down orientation where spiritual is up and mundane or material is down. They give a concept a spatial orientation, for example 'happy' is up, as in 'I'm feeling up today'. Having control of force is up; being subject to control or force is down ('I have control over her'; 'I am on top of the situation'; 'she's at the height of her power'). AMHPs used language related to interpersonal power, control and boundaries: full-time AMHPs were described by part-time AMHPs as having achieved a position in the 'lofty heights of hub' and the former also referred to their own 'heightened awareness' of and sensitivity to what was going on across the service. Part-time AMHPs indicated that they were at the 'bottom of the pile' when it came to influence.

It had not previously occurred to me, and it is not apparent from the literature, that some AMHPs perceived themselves to be part of a stratified system. AMHPs' relative full-time and part-time positions were cast in terms of promotion and demotion, whereby one part-time AMHP suggested that they had been relegated to the Championship and that full-time AMHPs perceived themselves to be in the Premier League.

A further metaphorical theme was apparent 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 vulnerability, both physically and emotionally (since the comment was in relation to working in a specific multi-disciplinary setting). Full-time AMHPs were seen to 'pull rank', indicative of discipline and battle, where (wounded) part-time AMHPs were 'up in arms' about this. It could be part of an antagonistic scenario in meetings, but it could also be more general where AMHPs across the service described 'battle fatigue' and referred to themselves as 'veterans', indicating a sense of survival of a combative experience.

Military or war metaphors pertained to struggle and the sense of battle for justice. These included descriptions of the local healthcare Trust as the 'enemy' which is 'like a beast [and] you have to get it in the central nervous system' in order to attack it effectively. They could convey difficulties with non-AMHP colleagues (usually doctors) or frustrations with differing interpretations of statute where 'there's now this big thing called 'capacity' which gets thrown up there and everyone has a shot at it'. At times, they conveyed a sense of disempowerment; they 'found themselves' in a battle that they were not winning (particularly around resources, medical approaches to assessment or longstanding power struggles with doctors). At times, this language extended into MHA assessment activity such as one AMHP who described a situation of 'brinkmanship' with a service user whom they believed to be acting in a manipulative way around engineering a hospital admission.

Perhaps most impactful was the language about pain, where part-time AMHPs talked about being 'burned' by their experiences about a 'stinging' encounter with a colleague. Discussions around recruitment to address the shortage of AMHPs was described in pessimistic terms of 'putting more logs on the fire'.

Related to this was an occasional use of metonymy where service users were referred to by diagnosis ('the personality disorder') or, more frequently, by sections of the MHA even where the people and their names were known to the AMHP. At such times, particularly where this was related to diagnosis, it seemed allied to an empathic failure and was an indication that the AMHP had less of a humanistic approach to their work (Camp et al., 2020). The use of metonymy in this way seemed consistent with Menzies Lyth's (1988) proposition that there can be an absence of any mechanism through which to positively help the worker to confront the anxiety-evoking experiences of their work. There were aspects of depersonalisation within AMHPs' work, most noticeably where people were referred to as sections of the MHA ('the s.136' or 'the 5(2)') where attention was paid to this specific category rather than to the wishes and needs of the person (Lees et al., 2013).

I came to realise how AMHPs used metaphoric and figurative language to describe elements of situations that are otherwise unaccounted for – tacit knowledge, where there are no written references that could explain or validate their feelings or experiences. It is a way of articulating the unsaid (Weiner, 1999), particularly where it linked with organisational identity and conflict. It is 'a fundamental characteristic of how people categorize and make senses [sic] of their experience' (Gibbs, 1992 p. 572). Metaphors are used to 'communicate a complex, patterned set of properties in a shorthand understood by the members of a speech community who share relevant mutual knowledge' (Glucksberg et al 1992 p.16).

AMHPs' subjective experiences were often controversial, or hard to convey, so the metaphorical use of language enabled them to 'frame' the topic in different ways, foregrounding what was important and making it real, apparent and spoken out loud as well as being associated with the 'elusive issue' of control (Bowker, 2009).

I had noticed that language of this type became more apparent at county meetings, within a larger group setting. The figurative language served to both contain and expand upon emotional experiences, with metaphors creating familiarity and allowing individual group members to form their own connections to it (Ettin, 1994). Figurative language enables groups to bond quickly and strongly and to share complex emotions, integrating experiences safely and productively (Young, 2008). Metaphoric communication allows sensitive subjects to be dealt with (Southall, 2012) and there is a relationship with coping and dissonance where it enables people to achieve distance from emotionally charged or distressing situations. Metaphor can create a fictitious experience which can be used to restore lost certainty and reduce dissonance (Oehrle and Fadely, 1992).

Overall, it seemed that using figurative language in this way acted as a buffer and helped to regulate emotional responses to difficult situations (Carmichael, 2000). It was, at times, difficult for AMHPs to communicate their sense of the complex interactions within their work and their language helped to capture its overwhelming, unspeakable and hazy aspects (Markmann, 2011).

Full-time and part-time AMHPs divided

I had not expected the restructuring of the service to have an impact on practice in the way that some of the AMHPs described it. There was an apparent separation of styles and practice in terms of whether AMHP work is merely functional and legalistic, or whether it is more allied to relationship-based, person-centred work. My diary notes highlighted that:

> *I'm not exactly sure but I think the debate here (at least for me trying to make sense of it) is around what they think they are doing there and whether there is a 'new look' AMHP work – but where does this come from? It's not law, national policy or anything that you can identify in reality.*

I observed regular, intensely passionate conversations amongst full- and part-time AMHPs which pertained to relationships and power. I had not expected to experience such a measurement of, as well as an assertion and negotiation of, perceived professional capital and status within the AMHP service. Full-time or part-time status seemed to demarcate difference with an emerging hierarchy that located one above the other with part-time AMHPs particularly now perceiving themselves to be at the bottom of this.

The act of allocating an assessment, and beginning the preparation for this, appeared to be seen as the allocator having pretentions towards an authoritarian, managerial role (which was problematic given the essentially independent and autonomous nature of the role) and the numbers of assessments undertaken per day were measured in terms of speed rather than by the effective, person-centred manner in which an assessment ought to be conducted.

I later learned that this was not necessarily a local development. When working on a national research project about AMHP practices, AMHPs were reporting that their services (particularly full-time AMHP teams) were developing troubling cultures wherein the work had become 'an exercise in who can do it the quickest', that there was a 'macho' environment and that attempts to slow down and discuss aspects of practice were met with a 'JFDI' approach and a 'just get on with it' response (Hemmington et al., 2021 p. 60). Again, reminiscent of Menzies Lyth's (1988) work, this may also be a way of managing the workload in that it rested on a sense of detachment and a denial of AMHPs' own feelings as well as an apparent expectation that they should not show emotion and maintain a 'stiff upper lip' (Lees et al., 2013).

On occasion, questions were asked as to who are the ‘proper’ AMHPs, or what makes a ‘good AMHP’ and sometimes ‘proper AMHPs’ were compared in passing to ‘part-timers’. I had not anticipated that the restructuring of the service and organisational processes would lead to perceptions of unequal power relations and an apparent shift in culture and, potentially, in the ways of practising AMHP work and attitudes around good practice. I had noted these phrases in my diary and had begun to ask myself the same question:

> *What is it they are trying to work out? What does ‘proper AMHP’ mean and why? Are they saying that it shifts, is organisational, personal, professional – does what I think differ from what they think? Am I being judgemental here, too?*

A similar sense of conflict was apparent in a related research project (Hemmington et al., 2021) whereby, as well as being ‘comrades’, and an essential source of support, AMHPs are their ‘own worst enemies’ who compromise each other’s independence:

> You get into work and find an assessment [already] booked … All the way along with training we’re told this is our [independent] assessment, we control it, that's what our role is. And yet we do it to each other. An assessment has already been arranged when we know damn well [we] haven't had time to [prepare]. We do it to each other all the time. So I think we’re the best people to have around. And also the worst to have around because … we don't do ourselves justice. I [want to] set my assessments up [and] choose who I will take with me, not them (p.68).

A further interesting finding, indicating a need for further evaluation, was in relation to part-time AMHPs who were employed by the healthcare trust. Their ‘liminality’ (I had noted one AMHP described it) and ‘outsider’ status came through when they described having to navigate some ‘difficult politics’. This was challenging in terms of a sense of identity, belonging and being ‘one of us’ but also, at an immediately practical level, one described missing various communications, information and guidance that were available to their Local Authority employed colleagues. This, they believed, meant that they were an ‘outsider’ and it put them on the ‘back foot’, left them feeling ‘professionally compromised’ and, inevitably, made them approach the work (and their colleagues) differently. I asked myself, in my notes, whether:

> *The preoccupation with nurses and SWs might be a red herring – here is a social worker talking about being an outsider – but that’s because they work for the Trust and so it’s organisational really.*

Full-time and part-time AMHPs united

AMHPs, however, put aside this divisiveness when united against a common enemy – the Healthcare Trust. Frustration and anger with a 'hierarchical' organisation was a familiar and recurring feature. AMHPs' shared frustrations enabled them to coalesce around the issue of the lack of resources, the lack of hospital beds (and the Trust's responsibility to find them) as well as around relationships with doctors and enacting the independent and autonomous nature of AMHP practice. In this respect, AMHPs were 'singing in tune', acting in 'harmony' or 'singing from the same hymn sheet'. In relation to healthcare trusts and testing experiences or relationships with doctors, AMHPs provided peer support to each other and became allies. At this point, a 'team' identity was apparent which was in keeping with earlier perceptions that, for AMHPs, peer support is key (Gregor, 2010).

Stress and AMHP work as emotional work

Contrary to my early expectations that the ethnography would merely bring me up-to-date in terms of my interview schedule, I found that the ethnographic field was not just an arid platform for law and policy. Consistent with the literature, stress and discord happened at the juncture between the rhetorical professional, legal and policy-based aspirations of the AMHP role and the actual, everyday enactment of the role.

AMHPs described anxiety and trepidation attached to being on duty, with a small number saying that they 'dread it'. One AMHP described the experience as being a 'hornets' nest' – they go in, mix it up and leave things in a bad way, particularly with carers and relatives. This trepidation was often attached to uncertainty around what to expect on any given day, an ever-present AMHP experience more latterly compounded by other difficulties. The biggest source of stress and anxiety was put down to the lack of hospital beds[21] and, as highlighted in the literature, the need to 'walk away' from people in need or at risk (Morriss, 2015; Vicary, 2017; Hemmington et al., 2021). Here, there was a clear sense of ambivalence and anxiety as the most stressful aspects of the role were around this lack of resources.

AMHPs' uncertainty was created by the lack of availability of beds, the implications of this, the lack of time due to a backlog of assessments, and the lack of alternatives to admission due to the lack of community and crisis services. This uncertainty appeared to be conflated with moral distress or moral injury, defined earlier in this thesis as constraints making it impossible to do

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[21] It later became apparent that this local authority area has an extraordinarily high waiting list for hospital beds.

the ‘right thing’, and where professionals may perpetrate, fail to prevent, or witness events that contradict their deeply held moral beliefs and expectations (Jameton, 1984) causing dissonance and inner conflict (Litz et al., 2009). Bourdieu et al. (1999) also identified ‘social suffering’ as being the gulf between the reality of workers’ occupations and their more deeply held ontological and professional beliefs (Smith, 2011). Some aspects of the work echoed AMHPs sense of abandonment as identified by Vicary et al (2019). One AMHP in this study stated that:

> *I am not willing to put myself in a situation where they [doctors] tootle off and I am left on my own for hours waiting for a bed or transport when someone could point a shotgun at me.*

Resources

The lack of hospital beds, community alternatives to admission, availability of police to attend MHA assessments (particularly where their attendance is essential, for example, for the executing of a warrant to enter premises) and difficulties organising transport to hospital (by police or paramedics) were all daily difficulties encountered by AMHPs. This was particularly problematic to the extent that AMHPs believe that the lack of resources dictates outcomes of MHA assessments. There were many ways in which AMHPs referred to the MHA assessment process as an increasingly administrative and bureaucratic task with one perceiving that ‘you are expected to get there and complete the process and just tick boxes and sort transport’. This frustration with AMHPs being perceived as providing a ‘sectioning service’ is not new (Webber, 2013) and was similarly expressed in this study where one AMHP suggested that others think that the AMHP service is ‘Sections-R-Us’ where colleagues can simply request a detention.

AMHPs continually expressed frustration about difficulties with multi-disciplinary working, with particular frustrations attached to working with some doctors. Some AMHPs believed they were not taken seriously, treated as a ‘lackey’ or reduced to ‘donkey work’. They described feelings of powerlessness and ‘impotence’ arising from the lack of resources limiting their opportunities to discharge their statutory responsibilities effectively. More broadly, this powerlessness was seen to be a consequence of working within their setting where one such employee stated that ‘we’re a Local Authority - we just bend over’ when it came to decision-making.

These relationship difficulties also occurred within the broader context of organisational division between the healthcare trust and the local authority social services department following the organisational de-integration process with its physical and organisational separation of services and employees. Again, metaphorical and figurative language expressed 'marital' and 'divorce' (although I was advised that this latter word was banned from use within the organisation) scenarios, with phrases such as 'the honeymoon with the Trust is over'. Occasionally, 'adultery' scenarios were referred to, where apparent transgressions and 'cosy' working relationships with doctors led to accusations of colleagues 'getting into bed with the Trust'. Generally, it appeared that relations between the Trust and doctors were coterminous in the AMHPs' perceptions and that roles and employing organisations were conflated. It appeared that this was observed and felt by the small number of Trust-employed AMHPs who described a liminality in terms of their experiences, outlined above.

Different styles of practice

Following Peay (2003) I recorded evidence of different styles of practice, both organisational and personal. Some AMHPs had a broad, legalistic style (conveyed through frequent reference to statute), some used values-based frameworks to describe their work, whilst others tended towards the administrative and processual, seeing the role as practical and functional, not necessarily aligned to any professional background.

I noticed differences in approach between daytime and out-of-hours work. As identified in the literature review, however, more work is needed to understand whether the differences in practice are of a cause or effect nature, as there is no research or precedent in this area. One or two concerns relating to night shifts having 'dark, shadowy atmospheres' and the impact of having to go down 'dark creepy lanes' to drop off medical recommendations were reminiscent of Smith and England's (1997) findings that the influence of the 'shadowy nights' did influence perceptions of risk and, consequently, styles of practice and decision-making.

One EDT AMHP explained that they choose to work in EDT precisely *because* of the aspects of lone working and independence, stating that 'I carry everything. The buck stops with me, and I like that'. Another AMHP, who covers some EDT shifts as well as daytime work, believed that EDT decision-making is more straightforward as 'it strips away layers of narrative', citing a service user's GP's or care co-ordinator's tendency to 'ramp up the risks'. Decision-making might be different if you only have the police to talk to and this same AMHP also pointed out that having even less resourcing overnight has an impact on decision-latitude.

AMHPs' styles are not evaluated in detail in the literature, but one interesting area became apparent. In Peay's (2003) research, AMHPs were described as having hawkish or doveish personalities and this resonated with my experience. Fundamentally a description of political actors and military interventions, some AMHPs appeared to take a more interventionist (hawkish) approach (‘we don’t piss about’), whilst others were more doveish, more conciliatory, aspiring to a more democratic way of working, sharing discussions and decisions more openly with service users. This was an area I was able to return to in later phases of the study. I observed AMHPs indirectly reflecting on styles of practice in their debates about what constitutes good practice and a ‘good AMHP’ or a ‘proper AMHP’, discussed above where a further example of this was where one AMHP described observing ‘gold, silver and bronze standards of practice’ in relation to the application of values and time spent with the person. Again, there are no textual representations of a ‘good AMHP’ which is something that the AMHPs seemed to wrestle with.

‘The One That Went Wrong’

Before I conclude this chapter, I have inserted an event which was an ongoing source of reflection which, whilst it occurring as part of an observed MHA assessment, was part of my ongoing ethnographic reflexivity. It is the event to which I referred earlier as ‘The One That Went Wrong’ in my research diary.

On more occasions than I anticipated I had to remind myself of my research goals and priorities (Emerson and Pollner, 1988). Remaining ‘just an observer’ in the midst of enticing events which have the potential to pull, engulf or seduce the researcher into deeper levels of participation is itself an achievement and researchers may need to periodically ‘remind’ themselves of their research goals and priorities (Emerson and Pollner, 1988). This became very clear in one scenario within which I became embroiled. It took place during (and following) an observed MHA assessment, but nevertheless my reflections were in keeping with ethnographic reflexivity.

One of the MHA assessments that was audio-recorded was in a busy Accident and Emergency department. The service user had been advised by the AMHP that the decision had been made to detain them. Extremely unhappy with this outcome, the service user unexpectedly got up from their trolley bed and tried to leave the department, shouting and making their feelings about the decision, and the AMHP, very clear. An A and E consultant appeared and quickly became confrontational, aggressive and sarcastic, directing much of their ire towards the AMHP. This AMHP had only relatively recently qualified and had done this through my own university programme. The consultant did not understand that AMHPs do not represent mental health services, as a matter of their employment or practice, and as such cannot ‘lay hands’ on service users and physically prevent them from leaving. The consultant was shouting at the AMHP about ‘doing some proper mental health work’ and shouting ‘call yourself mental health workers … this person is at risk’ and that as we had ‘triggered’ her agitation we needed to resolve the problem. Staff were arranging for security guards to return to the department to prevent the service user from leaving.

I could not, and cannot recall, whether the AMHP appealed for me to help, or whether I became involved as a matter of my own choice – but I moved rapidly from participant observer to AMHP practitioner, in an arguably more senior role to the AMHP who was by this point looking intimidated, alarmed and under attack. Without thinking and borne out of indignance (and possibly a sense of over-protectiveness) I stepped in to attempt to defuse the situation, asserted myself and firmly explained to the consultant why ‘we’ weren’t able to do as they wished, and also explaining the role of the AMHP. This too became heated, and the consultant began to loudly express their displeasure in my direction. The issue was resolved as security guards appeared and the service user was escorted to the ward (which was on the same site) – but there was a clear role shift for me from participant observer to what I had recorded in my notes as ‘parent/rescuer/person in authority/teacher’. But it was not my assessment. I felt as though I had undermined the AMHP, although a later debrief suggested that this was not the case as they had appealed to me for help and they were glad to have the support.

I have reflected on this at length. I do have more experience, but was I treating the AMHP as a student? Did I choose to assert myself as I perceived myself to be in a position of authority? Certainly, I was more experienced than the AMHP and was, after over twenty years in practice, used to being challenged and was not unduly alarmed as the AMHP appeared to be. In the heat of the moment, however, I lost my reflexiveness and research identity. On reflection, I was keen to defuse a challenging situation that was worsening with the service user. However, there was no reflection on my role as researcher. I don’t think I kept my feelings in check.

It was only when I was listening to the recording of the assessment and preparing the transcript did I realise that, during the assessment, the AMHP had in fact turned to me and asked if I had anything I wanted to ask the service user as part of the assessment itself. I wondered at that point if I could have addressed this issue (not least with myself) more satisfactorily.

I revisited this several times in my mind. I felt as though I had tainted my own research study. I wondered if I had wanted to challenge this consultant who had no managerial role, and I wanted to level the hierarchy. I was frustrated that ‘our’ AMHP role had been misunderstood. I flagged all these ‘red lights’ in my diary and thereafter tried to scrutinise any selection or interpretation biases around the data I was gathering to avoid any curatorial influences on the collection and interpretation of data (Yeo et al., 2020).

My own history, concerns and interests shaped the context of this research and I was not just a detached observer – I was also a narrator (Hagstrom and Gustafsson, 2019). I knew that data ‘doesn’t just happen’ (Olson, 2021) and I have known my own AMHP work to both empower and disempower – enacted in the moment – and I experienced anxieties and fears around this.

Conclusion

This ethnographical study was more than preparatory work for an informed and meaningful interview schedule. I was aware that AMHP services were undergoing restructuring and that there was a national move toward full-time AMHP services. Yet the influence of the environment, including hot-desking and territoriality, proved to be significant findings. Further, the apparent diverging ways of practicing from the practical (assessments fast and slow) to the professional (values-based practice and what makes a good AMHP). Fundamentally, full-time AMHP work has the potential to inadvertently influence the very nature of the work and its purpose.

AMHPs' use of language conveyed a high level of stress and, at times, distress. It was also, through the use of metonymy, indicative of signs of burnout. This was due to the nature of the work and is consistent with the literature. However, stress was also related to the organisational restructures and AMHP work as relational or moral work.

My reflections on my researcher role and the ways this was recorded in my notes became data that linked to my observations of others' practice. I had initially focused on the motivation that brought me to the research, but I went on to reflect on whether it was possible to retain a non-judgemental approach. I wondered whether I was moralising at times and I reflected at length on matters of insider/outsider roles. I wondered where I sat within the organisational hierarchies and reflected on issues of power dynamics and hawkishness (culminating in my intervention and subsequent feelings of crisis around 'The One That Went Wrong').

I had learned that the organisational restructure in the fieldwork site, and its ongoing impact, might influence practice in ways that I had not expected and I was keen to keep in touch with this. I was interested in continuing to follow protagonists or 'troublemakers', known for their dissenting views, who could be used to cross-check information (Beebe, 2001). I wanted to continue to 'follow the thing' (Marcus, 1995) and so I continued with the Rapid Ethnography study as I moved into the next part of the research. As I always aimed for applied knowledge, and as any influences on AMHP practice and decision-making were a rationale for undertaking an ethnography in an AMHP service, I continued to reflect on the research as 'political bricoleur'. The tacit power struggles, fissures and debates about identity and good practice seemed to be a regular aspect of the work and an unforeseen consequence of the restructure, and I wanted to keep in touch with this. Having undertaken this piece of work I appreciated Madden's (2010) observation that the:

> critical and transformative relationship of ethnography remains one of the most persuasive arguments for the ongoing importance of ethnographic research. (p.18)

I had wanted to understand the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make. Spending time with AMHPs enabled me to understand how different styles of hawkish or doveish practice, or reflections on what makes a good AMHP might go on to influence ethical approaches to practice including empowerment and involvement and SDM. The analytical lens now needs to be directed more clearly on the ways in which these observations influence AMHP practice and decisions about detention of service users under the Mental Health Act. In the following chapter I turn to my observational inquiry into these important encounters in the lives of service users and the routine practice of AMHPs.

Chapter Six: Mental Health Act Assessments Data Analysis and Findings

Following the layout of AMHP services and AMHPs' experiences more broadly, this chapter focuses the lens to provide an analysis of the Mental Health Act (MHA) assessment. It briefly consolidates AMHPs' specific roles and responsibilities in this regard, and then it focuses on AMHPs' activities and communicative actions within the assessment. This chapter presents an overview of three MHA assessments that were audio-recorded and transcribed, with Conversation Analysis used to analyse the data. I observed three assessments: one had been brought into hospital by police for assessment and was in a designated s.136 suite, one in an Accident and Emergency area and one in a private room in a hospital setting (although this person was not a current inpatient). The assessing AMHPs were from the service. The first assessment was with the AMHP and service user alone, and the second and third were joint assessments with different doctors.

Figure 6 below summarises AMHP and service users participants' backgrounds.[22]

<table>
<tr><th colspan="5">AMHPs</th></tr>
<tr><th>LA or Trust employed</th><th>Length of qualification</th><th>Regulated professional background</th><th>FT/PT AMHP</th><th>Gender</th></tr>
<tr><td>3 LA employed</td><td>1 under 2 years
1 2 to 5 years
1 over 15 years</td><td>3 Social Workers</td><td>3 Mixed role AMHP</td><td>2 male
1 female</td></tr>
<tr><th colspan="5">Service Users</th></tr>
<tr><th>Gender</th><th>Age range</th><th colspan="2">Experience</th><th>Current scenario</th></tr>
<tr><td>2 Male
1 Female</td><td>1 under 25
1 over 35
1 over 55</td><td colspan="2">1 1st assessment
1 fewer than 3 previous assessments
1 over 5 assessments</td><td>1 in A and E
1 s.136 (police referral)
1 in hospital</td></tr>
</table>

Figure 7: AMHP and Service Users' background data

Mental Health Act Assessments: Setting the scene

As outlined in Chapter One of this thesis, it is the AMHP who has overall responsibility for coordinating the assessment (DoH, 2015a para. 14.40) and, additionally, AMHPs are required to consider paragraph 14.42 of the Code of Practice to the MHA where:

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[22] Information has been presented so as to maintain confidentiality and anonymity.

> Given the importance of good communication, it is essential that those professionals who assess patients are able to communicate with the patient effectively and reliably to prevent potential misunderstandings (DoH, 2015a).

As part of the statutory competencies for practice, AMHPs are also required to

> promote the rights, dignity and self-determination of persons consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty (1c) (HMSO, 2008).

Given this, I explore the ways in which AMHPs' coordination role should be considered a fundamental part of the assessment itself and, further, that it is an opportunity for facilitating the Empowerment and Involvement principle as well as principles of Shared Decision-Making.

To explore this in detail in MHA assessments, I used Conversation Analysis - a fine-grained analysis of conversational patterns and manoeuvres – to illustrate the ways in which (dis)empowerment can be enacted. AMHPs may not even be consciously aware of the ways in which their interventions (particularly through repair) empowers service users to be involved in their assessments and, to an extent, decision-making.

In Conversation Analysis (CA), conversations are considered to be based on precise rules, structures and relational alignments between participants (Heritage and Sefi, 1992). A foundation to these structures is 'turn taking' where, put simply, when a person completes a turn of talk, it then becomes the other person's turn to speak (Sacks et al., 1974). Layers of complexity are added to this conversational convention, for example, what a speaker says is related to what the previous speaker has said in the preceding turn and, in CA, these are referred to as 'first part' and 'second part' or 'adjacency pairs' (Schegloff et al., 1973). How the hearer responds indicates to the speaker whether they have understood and, if not, steps are taken to remedy the misunderstanding by conducting repair in their next turn of talk (Schegloff, 1992). These conversational patterns or manoeuvres highlight the ways in which conversations are forwarded or blocked, and the ways in which empathy and epistemic domains and privileges are enacted. I focus, in detail, on these epistemic domains and privileges below as a means by which AMHPs can further reconcile this with their maximising service users' self determination as well as empowerment and involvement in practice. Prior to this I outline the significance of the types of questions as enactments of empathy and participation.

Types of questions

Open and closed question categories encompass numerous subtypes with different interactional consequences (Heritage, 2010; Raymond, 2010) and different gradients of empathy. For example, neutral 'survey' type questions convey a stance of objectivised indifference, representing a bureaucratic or 'anonymous' relationship. In contrast, effective professionals tailor their questions to a particular individual (referred to in CA as 'recipient design') representing a caring relationship with service users (Heritage, 2010).

Thompson et al (2015) and Thompson and McCabe (2016) outline different categories of questions used in psychiatric encounters which include:

- **Yes/no questions**: subtype of a 'closed' question, syntactically identifiable with an auxiliary verb[23] in the first position of the sentence, followed by the subject: *Do you go to a day centre?*
- **Wh-' questions**: have a question word (who, what, when, why or how) in the first position and they elicit information on a state of affairs or the property of an event. They are considered to be open questions because they do not project a specific response: *How does that make you feel? What do you mean?*
- **Declarative questions**: have the syntax of a declarative sentence and a rising intonational contour is likely to mean they are recognised as questions requiring (dis)confirmation[24]. They are considered to be 'closed' questions because they invite yes/no type responses: *So you feel a bit anxious? You feel happy about that? You're still on the same medication? Sleeping okay?*
- **Tag questions**: transform a declarative statement or imperative into a question by adding an interrogative fragment (the tag), i.e. an auxiliary verb followed by a pronoun (isn't it, would he, do you). Like yes/no questions and declaratives, they invite (dis)confirmation and as such are another class of 'closed' question: *You're on 20 mg now, aren't you? You were thinking of going to college, weren't you?*

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[23] Auxiliary verbs often express distinctions of tense, aspect or mood and include the verbs do, can, will, have or did: 'Did you really believe it at the time?', 'Have you asked your GP about that?', 'Will you think about reducing your depot?', 'Do you ever feel someone is controlling your mind?' and so on (Thompson et al., 2016).

[24] They can be coded with a question mark when transcribing. Additionally, data analysis views the next turn (the conversational response) to see whether the sentence had indeed been understood as a question where recognition of questioning depends on sequential, prosodic and epistemic features, not syntax alone (Gunlogson, 2002; Heritage, 2012; Stivers and Rossano, 2010).

Out of these, declarative questions are the most effective: they are indicative of better engagement and perceptions of the therapeutic relationship, and they display an understanding of service users' perspectives and emotional experiences. In particular, '*so*'-prefaced declaratives are hearable as displays of empathy (Ruusuvuori, 2005), understanding (Antaki, 2008) and active listening (Hutchby, 2005), displaying a more 'knowing' stance than other question types (Heritage, 2010). Conversely, 'wh-' (open) questions convey less understanding and invite more elaborate responses and, particularly in psychosis, correlate with more severe positive symptoms and worse perceptions of the relationship (Thompson et al., 2015; Thompson et al., 2016). Prefacing the declarative with '*so*' (a 'discourse marker') is a way of recognising 'inferential or causal connections' with the prior talk (Bolden, 2009, p. 974) and the speaker can therefore frame the declarative question as closely resulting from (and contingent upon) the person's prior talk (Schiffrin, 1987).

Extract 1[25] illustrates how an AMHP used a so-prefaced question at lines 14 and 19 as an affirmatory display of active listening:

Extract 1 (AMHP 2):

1 Dr: You have been … experiencing anxiety? .hhh Or you don't
2 think you .hhh are an anxious person (.) You haven't been
3 experiencing any .hhh anxiety or low mood?
4 SU: I (.) I .hhh I can't say if it's proper anx::iety as such
5 AMHP: = Do you have times when you are fighting for breath or .t
6 anything like that?-
7 SU: = ..hhh not overly, no .. I think I've been al'reight (.)
8 just sometimes things get on top o' me and that-
9 Dr: Yeah what about palpitations and things like that.
10 SU: (.).hhh hhh. (.) **I don't know** .hhh I might get a bit
11 edgy but-
12 Dr: [Dizzy (.)] ummm dry mouth .hhh things:: like that
13 SU: Well I (.) ummmmmm (.)
14 AMHP: [**So you're**] saying that at times you get a bit
15 … um (.)hh. agitated when you have a lot to manage in life,
16 but: you wouldn't say it's a full-on anxiety issue
17 SU: hhh. yes that's about right .hhhhh **just at times of stress**
18 and that's (.) err not summat I need treatment for

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[25] For clarity, I specify which MHA assessment these transcripts are drawn from. AMHP 1 was assessing alone; AMHPs 2 and 3 were assessing jointly with doctors.

19 AMHP: [yes .hh **so]** **it's** stress
20 related hhh. and so you're not thinking <mental illness> as
21 such are you-
22 SU: [No, #no]
23 Dr: [**I think**]you have been describing anxiety .hhhh
24 and so **we must decide** what to do about th (.) this thing

Using so-declaratives in this way also enables the AMHP to conduct topic transition sensitively, whilst giving the impression of refining their account based on the service user's own account, thereby demonstrating listening. This also plays a role in restoring the service user's involvement and position (or epistemic domain, outlined below). At line 17, where the service user says the problems exist 'just at times of stress' they orient to a socially-derived explanation for which the AMHP offers support. The doctor has been aligned with a biological explanation, but the service user presents an alternative (and legitimate) explanation around stress which is aligned with the AMHP's own social perspective. The AMHP endorses this, reinforcing the service user's position.

An important resource within CA research is the notion of knowledge (or epistemics) and how speakers interact in terms of 'who knows what', 'who has the right to know' and 'who has access' (Landgrebe, 2012). This is seen to originate from Goffman's (1967) demonstration of the ways in which participants do interactional work to maintain 'face' and how they inhabit 'territoriums' to which they have primary rights (Goffman, 1971 p.38). Sacks (1970; 1984) similarly demonstrated how interlocutors possess different rights to first-hand knowledge and second-hand knowledge (Sacks, 1984), and Labov and Fanschel (1977) developed the concept of A and B events and epistemic domains. Given the importance of self-determination, empowerment and involvement in communication an understanding of social epistemics is critical[26].

Epistemics in language

Social epistemics is concerned with the ways in which participants handle knowledge distributions amongst themselves through the organisation of conversational sequences (Heritage, 2012; Kasper and Wagner, 2014). It addresses the connection of knowledge and

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[26] I have subsequently introduced these concepts as part of my own post-qualifying training with AMHPs as a way of deepening their practice knowledge and developing their report-writing. My experience within training (consistent with the interviews with AMHPs discussed in the following chapter) has been that they are not confident around how they *apply* the relevant practice imperatives and, in particular, how they are consolidated in their mandatory report-writing.

social organisation (Stivers et al., 2011). By managing epistemic status, stance, access, rights, and obligations in their conversations, participants produce their identities and social relations (Wilkinson et al., 2003; Heritage and Raymond, 2005). Conversation Analysis looks at the way that participants assert, contest and defend their claims to knowledge (and arguably power) within their interactions. They adjust their actions and understandings in keeping with what they know about the world (Heritage, 2013).

Service users, doctors and AMHPs constitute separate epistemic communities and as such they own their associated identities, beliefs, knowledge, experience and, sometimes, idiosyncratic language (Heritage, 2008) including jargon. Usually, conversationalists treat one another as possessing privileged access to their own experiences and as having specific rights to narrate them (Pomerantz 1980; Sacks 1984). Of particular interest here are the aspects of privilege and sharing.

Epistemic Domain and Epistemic Stance

Concepts of epistemic domains are developed from Labov and Fanshel's (1977) 'territories of knowledge' where there is a distinction between A-events (known to A, but not to B) and B-events (known to B, but not to A). Kamio (1997), building on this, developed the idea that A and B each have their own 'territories of information' and any element of knowledge can fall into both territories, but often to different degrees.

Speakers use different methods to convey commitment to their statements. By way of example, Heritage (2013 p.371) illustrates the different ways of deploying commitment to the possibility that it is raining:

- It's raining
- It's raining, isn't it?
- Perhaps it's raining
- It might be raining
- I think it's raining
- I heard it's raining
- I wonder if it's raining
- Don't you think it's raining?
- Do you think it's raining?

Each has the same propositional content about the rain, but the epistemic stance embedded in the grammar of the sentences is different (Heritage, 2013).

A speaker's epistemic stance (or epistemic position) signifies their knowledge and beliefs about a subject as well as the commitment to the truth of what they are communicating (Ochs, 1996; Bongelli et al., 2018). It can be defined as the 'attitudes, feelings, judgments, or commitment concerning the propositional content of a message' (Biber and Finegan, 1989, p. 93). It is made apparent through different grammatical devices (or 'stance markers') including modal auxiliaries (may, might, can) to adverbial hedges (probably, actually, likely). These stance markers also convey how certain or confident a speaker is about the veracity of the content of their conversation (Biber, 2006).

In Extract 1 above, at line 10, the service user responds to questions about anxiety initially with a gap of silence, followed with 'I don't know … I might get a bit edgy but …'. Here, the lengthy silence is a resource from which the AMHP can interpret a sign of trouble, and the following 'I don't know' may have the function of a hedge (Weatherall, 2011) or an avoidance of commitment (Tsui, 1991). In terms of stance taking, Heritage (2012) argues that when a participant adopts the epistemic stance of 'unknowing' (here, through 'I don't know') they invite an elaboration and sequence expansion. 'I don't knows' (IDKs) are one of the most frequent epistemic stance markers (Kärkkäinen, 2003) and the AMHP's response indicates that they have noticed the service user's apparent lack of commitment to the conversation pertaining to clinical talk and they have repaired[27] it by reiterating the service user's epistemic stance. This is also one example, amongst several throughout the assessment transcripts, where the AMHP returned the 'voice of the life world' from the 'voice of medicine' (Mishler, 1984) to the service user. This conversational turn accommodated and restored the person's understanding and competence. At line 23, however, the doctor's 'I think' projects a 'knowing' epistemic stance which serves to invite confirmation and close the sequence (Heritage, 2010; Raymond, 2010). The doctor also follows this with 'we must decide' at line 24, confirming the suggestion that 'I think' predominantly occurs in types of activities with a task-oriented goal, where participants are to establish agreement and 'I think' functions as a 'boosting' device to close the conversation (Kärkkäinen, 2003; Landgrebe, 2012). In sum, epistemic stance is concerned with how speakers position themselves through the design of conversation (Heritage, 2012) and how they do this depends upon their epistemic status.

Epistemic Status and Deontic Status

Epistemic status is not only the possession of information but, also, it is the *distribution* of rights and responsibilities regarding what participants *can* accountably know, how they know it and *whether they have rights to possess and articulate it* (Heritage, 2006). It is based upon the participants' evaluation of one another's epistemic access and rights to specific domains of knowledge and information. Epistemic status concerns the *expression* of relationships, as

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[27] Repair is discussed in further detail, below.

managed through the design of conversation (Heritage, 2013). For example, people's thoughts, feelings, experiences, hopes and expectations are usually generally treated as theirs to know and describe (Labov and Fanshel, 1977; Sacks, 1984; Heritage, 2011). Mental health professionals hold authority contained within their professional perspective or 'epistemics of expertise', however, they only have secondary access to knowledge about a service user's life, situation or 'epistemics of experience' (Heritage, 2013). Consequently, conversations within institutions and within professional identities bring additional matters of epistemic access and authority. In interaction between professionals and service users, access to institutional language is typically and often normatively limited to the professional. The epistemic status differential between professionals and lay participants is reflected in, and constituted through, asymmetric access to institutional speak (Kasper and Wagner, 2014) including jargon and 'coding' through medicine or knowledge of the law or resources.

Embedded within this is deontic status, relating to participants' rights to determine their future courses of action or 'how the world ought to be' (Stevanovic and Peräkylä, 2012). Allied to epistemic status, people also have deontic rights in different contexts, and they manage this in different ways. This is illustrated in Extract 2, where the doctor's *announcement* of a decision at line 1 ('you are going to need to') indicates their higher deontic status than the service user:

Extract 2 (AMHP 3):

1 Dr: OK (.) ah (.) .hhh so **you are going to need** to ummm restart
2 your medication or consider a different one.
3 SU: Mmmm

When speakers request information, they presuppose that their recipients have epistemic access, whereas when they do announcements the presupposition is that the recipients do not have epistemic access (Stivers et al., 2011). In the second example (Extract 3) the AMHP *proposing* an outcome (in the form of a question) claims more equal distribution of deontic status. Additionally, the use of 'we' at line 1 serves the purpose of attempts at engagement:

Extract 3 (AMHP 2):

1 AMHP: Well (.) .hh Dr ((Name)) is suggesting that **we** could consider
2 whether your medication is errr (.) doing its job?
3 SU: Right .hhh (.) OK-

Arriving at a joint decision involves an interaction between the epistemic and deontic status of the participants, and participants must also have sufficient knowledge of the content and context of the conversation (Ekberg and LeCouteur, 2020). To achieve this, there must be an assertion from one participant and an approval and commitment to this by the other participant (Stevanovic, 2012).

Rights and responsibilities concerning what participants know, and have rights to describe, are explicitly oriented to in conversation (Heritage and Raymond, 2005). Service users' responses may accept or resist the previous speakers' claims about deontic status:

Extract 4 (AMHP 3):

1 Dr: **Do you think** you **could** talk with (partner) (.) umm .hhhh the
2 fact that you were **quite** so bothered about the neighbours?
3 **Just** (.) that she might errr maybe (.) help out and see it
4 differently.
5 SU: **Maybe** .tch **but I know** what she'd say .hhh and how she thinks
6 (.) **You don't** (.) know what she's like hhh. **you have no**
7 **id::ea**
8 Dr: Mmmmmm,-
9 SU: [She] **always** seems to think it's made up (.) tch. **Every**
10 time I hear something (.) she **always** thinks it's (.) in my
11 mind-
12 Dr: uhhh (.) hhhhh .tch
13 AMHP: And so (.) so what would you normally think in that situation
14 then (.) .hhhh how do you explain it differently? What would
15 you do?

The doctor's proposal (line 1) was framed as an interrogative but downgraded with an epistemic marker (*do you think*) and the use of a modal auxiliary (*could*) and by downgrading devices (*quite, just*) (lines 2 and 3) display that the proposal has a contingent nature (Curl and Drew, 2008), and this serves to invite the service user to either accept or reject it thereby partially sharing the deontic right to make the decision (Stevanovic and Peräkylä, 2012). However, it is the doctor who provides this initial proposal, rather than asking the service user for their own ideas, and the doctor thereby displays a higher epistemic and deontic status and stance in relation to the service user's future action. Deciding to agree with a proposal for future action is not the same as choosing your own action (Ekberg and LeCouteur, 2020).

At line 5, the service user's response (*Maybe … but …)* indicates a lack of satisfaction with the doctor's deontic status, and they pursue a firmer deontic position with the interaction. Their response (*I know … you don't know …)* regarding specific knowledge about their partner and home circumstances resist the preconditions of the proposal (an 'inability to comply account') (Heritage, 1984) whereby they are unable to accept the proposal because they know, from experience, that their partner might not prove to be helpful in this situation. By saying '*you have no idea*' (lines 6-7) they are laying claim to an absolute epistemic advantage in which they project knowing about the matter whilst all others are entirely unknowing about what is being described.

Further, in using the adjunct *always* and *every* several times (lines 9-10) they are offering their account as a factual and global description of what happens as well as their superior direct knowledge of life at home. There is a lack of epistemic congruence, and the doctor has displayed their superior epistemic authority in the domain of the service user's experience who then invokes his deontic right to reject the doctor's proposal. In lines 13-15, by comparison, the AMHP invites the service user to provide their own ideas for what to do, rather than proposing their own, thereby privileging the service user's epistemic and deontic stance and authority over their own experience and future actions. The service user's thoughts represent 'B-event information' (Labov and Fanshel, 1977) and are mutually conceivable as the service user's own epistemic domain.

Epistemic Asymmetry

Professional and service user interactions are characterised by several asymmetries that are created through the differences in their roles, knowledge bases and expectations. The doctor is the expert who possesses formal biomedical knowledge and authority, whilst the service user has a social and personal lay perspective (Lindström and Karlsson, 2016) and these are not always in unity as participants orientate to their own respective epistemic domains. To make an objective conclusion and diagnosis, the doctor requires specific and often measurable information about symptoms. However, the person may have difficulty in providing (or be unwilling to provide) this type of information. This problem was illustrated in Extract 1 above where the doctor was seeking a specific label for the service user's problem (at this point in the conversation, anxiety) (line 1) but the service user expressed trouble in finding a label that would capture their subjective experience.

Epistemic asymmetries can be related to the dimensions of access, primacy and responsibility. Box two, below, adapted from the work of Stivers et al. (2011), Lindström and Karlsson (2016) and Mishler (1984) summarises this:

Dimension / participant	**Epistemic access / Epistemic domain**	**Epistemic primacy / Epistemic status**	**Epistemic responsibility**
Service User	First-hand knowledge of one's physical / mental health experience	Right to describe one's experience using the 'voice of the life world'	Brings information on subjective experience
Doctor	Professional knowledge based on medical education and experience	Authority to decide what is relevant and to diagnose and prescribe 'voice of medicine'	Brings medical information and treatment options for medical examination
AMHP	Professional knowledge of statute; alternatives to admission; social perspectives	Independence; Empowerment and Involvement principle	Self-determination; SDM; Applicant

Figure 8: Epistemic Dimensions and Asymmetries in Interaction

A service user's *epistemic access* is their direct, first-hand knowledge of their own experience, whereas doctors have greater knowledge of medical symptoms and their causes. With *epistemic primacy*, service users are entitled to their subjective experience as well as their right to communicate it. Doctors, however, have authority to decide what is relevant (or 'appropriate') to discuss and they are responsible for giving adequate diagnoses, information, and treatments, but this task (usually) depends on intersubjective trust. This means that the information that the person provides likewise needs to be adequate (Lindström and Karlsson, 2016). AMHPs' epistemic access and domains are varied and manifest themselves in several ways. AMHPs oriented to different aspects of the role within their assessments and decision-making which had similar domains to those identified in Chapter One of this thesis. AMHPs outlined the range of their professional and epistemic responsibilities;

AMHPs' work is *practical and processual*, as they have a role around coordinating MHA assessments and attempting to find alternatives to admission:

Extract 5 (AMHP 1):

AMHP: When we organise an assessment errr we don’t just look at
(.) at whether you need to be in hospital we sho:::uld also
be looking at whe::re there are any .hhh less restrictive
alternatives to this.
SU: Ohhh↓ (.) £let’s hope so

It is a *statutory, legalistic role* where AMHPs are seen as having expert knowledge of relevant statute:

Extract 6 (AMHP 3):

AMHP: It’s my role to look at (.) whether the Mental Health Act
applies ummm (.) and (.) .hhhh whether you have a (.) a
(.)mental disorder which means that we have to .hhh make
decisions about that,
SU: Oh

Professional aspects of the role include AMHPs’ social perspective, anti-oppressive and anti-discriminatory practice and the requirement to maximise service users’ self-determination:

Extract 7 (AMHP 1):

AMHP: It’s important that we work in partnership (.) umm (.)
and my role (.) is to make sure that we under::stand who
you are (.) as well as umm .hhhhh looking at treatment and
diagnosis and umm (.) things like that
SU: [Right right hhh.]

There are *moral and ethical dimensions* that arise from the independence of the role and the need to balance state paternalism:

Extract 8 (AMHP 2):

AMHP: We need to (.) umm balance .hh what is right and fair ummm
(.) and it might be the case that it would be a worse
outcome for you to be .hhhh in hospital (.) This is what I
need to look at (.) to balance umm .t the scales
SU: That’s good hhhhhhhh.

The work is *relational and interpersonal* involving critical awareness of the self in practice:

Extract 9 (AMHP 3):

AMHP: I try my best to be honest (.) £we are all human beings
and we need to understand each other as best we can so we
get the best outcome we can for each other umm .hhhhh is
it worth you explaining to me what you find difficult?
SU: Yeah hhhhh. Yeah OK .hhh So-

A summary of findings at this point indicates that there are specific types of questions that serve to forward or block conversation and that these are subjectively and objectively important in hearing and inviting service users' thoughts and preferences. There is evidence that AMHPs coordinate movement within the assessment itself and have techniques that can return the floor and restore privileges to service users. At times AMHPs align themselves with service users and share perspectives. AMHPs shift their identities, alignments and epistemic communities as part of their communication. In this sense their communication may be more nuanced than absolute or directive statements made by their medical colleagues.

Epistemic domain and conversation

Relative epistemic access to a subject is stratified between participants and, as such, they occupy different positions on an epistemic gradient (K+ and K−) which can vary from shallow to deep (Heritage, 2010; Heritage 2012). This is summarised in Figure 5, below:

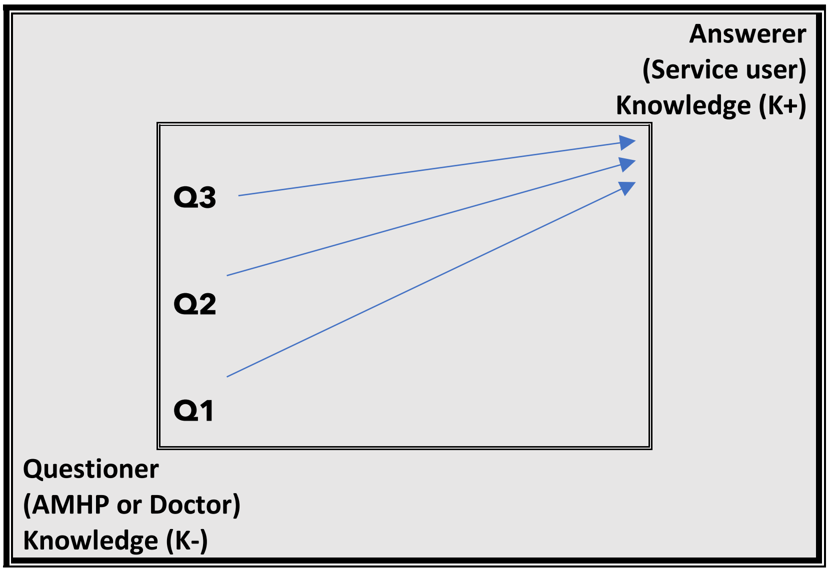

Figure 9: Epistemic Gradients

A shallow gradient represents a small knowledge (or certainty) gap, and a deep gradient represents a large knowledge gap. This relative positioning models participants' comparative epistemic access/domains – it involves the parties' joint recognition of their comparative access and knowledgeability and informs their rights relative to some domain of knowledge (Heritage and Raymond, 2012; Heritage 2013).

Gaps between a less knowledgeable (K-) questioner and a more knowledgeable (K+) respondent can be made apparent (Heritage, 2012; Bongelli et al., 2018). The 'epistemic gradient' (Heritage and Raymond, 2012) is a fundamental concept here, since the act of questioning invokes a claim that the questioner lacks certain information (a K- position) whilst simultaneously invoking the claim that the addressee has this information. The addressee is projected as being in a knowledgeable (K+) position. The act of questioning itself therefore invokes this relative K−/K+ epistemic gradient between questioner and answerer.

Epistemic stance, as articulated through different question types, can highlight epistemic asymmetry. Thompson and McCabe (2019) illustrate the different epistemic gradients established by questions such as:

> Q 1) Do you feel a bit anxious? (Yes/No interrogative)
> Q 2) You feel a bit anxious, don't you? (Tag question)
> Q 3) You feel a bit anxious? (Declarative question)

Whether the person 'feels a bit anxious' is B-event information (Labov and Fanshel, 1977) in that it is only properly known by them, it is within their epistemic domain, and they have epistemic access, primacy and status. However, the questions above represent distinct stances towards that information (Thompson et al., 2016) as illustrated in Figure 5, above.

The questions are on three different levels of the epistemic gradient, from K− to K+. Each question addresses information that is within the epistemic domain of the service user (K+) (Heritage, 2013) but where the epistemic stance of the professional (K-) varies according to their degree of knowledge. Q1 indicates that the questioner has no certain knowledge of the person feeling anxious, indicating a steep epistemic gradient between the knowledgeable (K+) service user and the relatively 'unknowing' (K−) professional. In contrast, Q2 indicates a shallower gradient by the questioner's greater confidence or knowledge that the person does indeed feel a bit anxious. Whilst delivered initially as a declarative statement ('you feel a bit anxious'), the questioner's epistemic entitlement is downgraded with a tag question (Heritage, 2012, p. 12) '*don't you?'*, seeking confirmation of the assertion made in the declarative component. Finally, Q3, a declarative question without an interrogative fragment (Q2) or auxiliary-subject preface (Q1), seeks to reconfirm or, alternatively, convey inferences, assumptions or other kinds of ‘best guesses’ (Heritage, 2010 p. 49) and is consequently the shallowest gradient denoting the narrowest knowledge gap.

While Q1, Q2, and Q3 are all versions of ‘closed’ questions that aim to solicit the same information from the service user, the selection of one form over another can invoke contrasting social relations between speakers and have significant consequences for the ensuing interaction. Taking the ‘unknowing’ stance of a Yes/No interrogative (Q1 type) can invite elaboration:

Extract 10 (AMHP 3):

AMHP: So I’m guessing that when the neighbours turned up the music you felt quite angry?
SU: Yeah .tch (.) but they do::: it to get a ri:::se and to threaten us
AMHP: Oh .hhhh I see so it’s not just the loud music then-

Conversely, the ‘knowing’ Yes/No declarative form (Q3 type) merely invites confirmation of known information by the recipient, who is projected as an authoritative source (Heritage, 2010):

Extract 11 (AMHP 2):

Dr: That made you get ang::ry then?
SU: Umm (.) .hhhh yes really
Dr: Ummm (.) hhhhhh. right so:::::

The role of territories of knowledge in conversation has significance. For example, epistemic status can be simulated by professionals who deploy epistemic stance to appear more, or less, knowledgeable than they really are, a stance often used in therapeutic interventions such as Cognitive Behavioural Therapy and referred to as Socratic questioning or the role of the naïve enquirer (Kazantzis, 2014). Here, professionals deliberately position themselves in a relatively unknowing (K−) position and initiate talk by inviting or eliciting information from a (projectedly) more knowing (K+) recipient:

Extract 12 (AMHP 3):

AMHP: So:: I’m a bit puzzled. .hhhh if I’d never been to your estate before and never met your neigh::bours until today .hh and then I heard them play that song (.) .hhhhh what sort of message would I be get::ting from that?

Alternatively, knowing (K+) speakers can initiate talk and sequences and justify this by projecting the hearer to be in a relatively unknowing (K−) position:

Extract 13 (AMHP 3):

Dr: Well .tch I’m think::ing about wheth::er you are experiencing paranoia. .hhhh ‘cause it sou::nds to me that this is what we’re looking at you .hhh hhhhhhh. you (.) seem to be thinking about things that are not rea::lly there?

The Mental Health Act assessment

AMHPs have a specific role at the start of a MHA assessment where they:

> should identify themselves to the person being assessed, members of the family, carers or friends and the other professionals present. AMHPs should ensure that the purpose of the visit, their role and that of the other professionals is explained (DoH 2015, para. 14.51).

This official opening, with its emphasis on the weight of statute, indicates that the upcoming discussion is going to be a formally constrained and delimited one. Evidence also suggests that it is an intimidating scenario (Blakley, 2021), not least for a potential outcome being loss of liberty.

Mental Health Act assessments open with a ‘bureaucratic role format’ (Strong, 1979) where professionals (and potentially service users) adopt their roles and collaboratively produce a ceremonial order with inherent rituals. At the start of an assessment, AMHPs should ‘identify themselves … [and] ensure that the purpose of the visit, their role and that of the other professionals is explained’ (DoH, 2015a para. 14.51). Given this, there is less likely to be the typical round of phatic communication, or ‘language used in free aimless, social intercourse’ (Malinowski, 1922), whose purpose is to establish friendships and sociability through ‘ordinary chat' or 'small talk' such as 'how are you' or a conversation about the weather (Burnard, 2003). Phatic exchanges are the 'lubrication' in a conversation (Burnard, 2003) but MHA assessments will typically begin without particularly in institutional settings where participants are likely to orient quickly to a core goal or task (Drew and Heritage, 1992).

These rituals arguably have a greater meaning than their bureaucratic ones. Goffman (1967) described the structure and 'psychosocial mechanics' in face-to-face interaction and its 'behavioural materials' which include glances, gestures and verbal statements. As we automatically interact with other through talk, gesturing and thinking about and judging one another, we claim a face for ourselves. 'Face-work' is the effort to act into a role through rules and the ritual. We act within the scripts and rules of conduct we have internalised, and social interaction becomes adherence to, or deviation from, accepted norms.

Each of the three MHA assessments in this study opened with the AMHPs explaining the (statutory) purpose of their visit, overseeing introductions and thereby establishing identities. The professionals introduced each other, using their professional titles, and the service user did not speak – apparently as they were already without identity in the scenario. None contained any phatic communication – all went straight to the business of the assessment. Significantly, there were different approaches to this in terms of who went first, an aspect of communication which goes beyond the conventions of habit.

MHA assessments and power: Who goes first?

In the first assessment, the AMHP introduces and quickly hands over to the doctor:

Extract 14 (AMHP 2):

1 AMHP: So .tch this is Dr ((Name))
2 SU: >Hi pal<
3 AMHP: So Dr ((Name))is go::ing to ask you some questions about
4 your (.) mental health that we (.) we need to be thinking
5 about-
6 SU: [yeah yeah]
7 AMHP: [**OK?**]
7 Dr: Right .tch

In the second assessment, there was no such straightforward handover or smooth start:

Extract 15 (AMHP 3):

1 AMHP: Hiya ((name)) um .hhh so I am an Approved Mental Health
2 Professional and I am part of the team who has come to
3 assess you-
4 Dr: Hello ((name)) and I am Dr ((name))and my role is .tch (.)
5 to examine you now to see whether you need hospital (.) or
6 some:thing else
7 AMHP: [AND WE HAVE] COME TO talk to you about what's
8 happen:ing **more generally** at the moment-
9 SU: OK yes I've done this before-
10 AMHP [So what] happened? Um .hhhh
11 What's been happening?

Despite AMHPs' remit to make introductions, as well as their coordinating role, there is a habit whereby AMHPs will hand over or defer to doctors to lead the assessment (as with Extract 14). In Extract 15, however, the AMHP starts the assessment, and the doctor then introduces themself (uninvited) (line 4) which leads to a loud overlapping of the talk (lines 6 and 7) as the AMHP continues. This indicates a competitive element to the talk, and it illustrates tensions around power and who takes the lead and thereby the floor space.

Introductions are important as empowering acts and it appeared from these assessments that AMHPs were not considering them in a purposeful way. The way an assessment opens appears to mean that identities are quickly established. The literature indicates that MHA assessments are often consistent with Garfinkel's (1956) 'status degradation ceremony' which are associated with shame, guilt and diminishment particularly denoting the removal of the self from public view and the removal from the regard of the publicly identified 'other'. The transformation of identities is the destruction of one social object and the constitution of another and it effects a recasting and reconstituting of the person as they are 'placed outside [and] made strange … in the eyes of his condemners' (p.420). In all three MHA assessments observed here, the professionals would introduce themselves and the purpose of the visit and by moving straight into the business of the law, or of medicine, stripped the service user of their personhood. None were asked to introduce themselves.

In CA, 'preference organisation' refers to the set of practices through which participants manage activities that either promote or undermine social solidarity (Pomerantz, 1984; Sacks, 1987; Schegloff, 1988). In MHA assessment scenarios, whether one person's view is the more significant or more authoritative in a specific context may be linked to claims to epistemic authority arising from the first speaker going first (Heritage and Raymond, 2005). This turn-taking here was illustrative of the establishment of power and authority, and the service user waiting to be addressed and invited to speak with each turn. In conversations, CA holds that the first speaker would have a claim to epistemic primacy simply by virtue of the sequential position of going first (Heritage and Raymond, 2005) and in so doing they establish a representational field around which the second speaker will need to position themselves through agreement, disagreement, or adjustment (Pomerantz, 1984; Heritage, 2002). The first speaker, in aiming to go first and lead the assessment, has proposed a terrain and an implied claim that they have primary rights to evaluate the matter and thereby putting in place the consequential negotiation of who is agreeing with whom (Schegloff, 1996, p.177) or 'the terms of agreement' (Heritage and Raymond, 2012).

In Extract 14, the AMHP projects an agreement at line 7 ('OK?'). In Extract 15, however, both doctor and AMHP are making adjustments or even expressing disagreement. At line 8 the AMHP is asserting a disagreement by stating that the assessment is 'more general' than looking at 'hospital or something else'. This challenge also serves to promote a more symmetrical distribution of authority between them and the doctor.

In the third assessment (Extract 16, below), the AMHP is seeing the service user alone, having already received two medical recommendations:

Extract 16 (AMHP 1):

1 AMHP: Hi ((name)) my name's ((name)) and I'm an Approved Mental
2 Health Professional .hhhh um (.) as you'll know you've ummm
3 seen two doc:tors (.) ahh and they think you .tch ne:ed to
4 errr (.) .hhhh be in hospital so I need to hhhh. **follow**
5 **this up** to see .hhhh what **we**[28] do::.
6 SU: (..) .t (..) () .t ()
7 AMHP: OK .hhhh so hhhhhh. so you took an overdose-
8 SU: [Yeah hhhhhhh.]

Interestingly, despite assessing alone, the AMHP defers to medical authority by saying that they are 'following up' on what the doctors think (lines 4-5). In Extract 17, below, the AMHP

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[28] It is possible that the 'we' at line 5 is doing the interactional work of the AMHP engaging the service user, but later in the transcript the AMHP turns to me to invite me to take part in the assessment and they could be referencing the AMHP 'we' in the room.

continues the conversation by using a tag question at line 3 (*isn't it?*) which serves to cancel the suggestion that they are assuming K+ rights simply by going first:

Extract 17 (AMHP 2):

1 AMHP: OK .hhh so ummm (.) **so you drank heav::ily .hhh took an**
2 **overdose and then** (.)somehow the police were in in your
3 house and you drank uhmm .hhhh that's a problem **isn't it?**

Overlap or simultaneous talk

Extract 15 above illustrates the ways in which different parties can persevere with a battle for survival in the competition for the turn space where a number of resources are deployed including volume or 'acoustic force' (Raymond, 2018) where the AMHP was audibly louder than the doctor (line 7, denoted by capital letters). Within the same transcript, there were later examples of conversation appearing to be pugilistic. These highlight where turn-taking and overlap become a 'battle for survival' or 'fight for the floor' (Raymond, 2018). In conversation, overlapping talk should result in one or more speakers dropping out, and it becomes noticeable when they don't as interrupting is self-selecting against the rules (Lestary, 2018). An immediate resolution would be for one or more of the parties to stop talking before they have completed their turn, but Heritage and Raymond (2005) raise an apt question here:

> …. which one should stop? Aye, there's the rub! (p.7)

This is reminiscent of Goffman's (1971) 'Territories of the Self' with their range of 'territorial preserves' and ways in which their boundaries are 'patrolled and defended by the claimant' (p.52). Heritage and Raymond (2005) contend that rights to evaluate states of affairs are similarly patrolled and defended by individuals in routine conversational practices. Here, there are apparent professional or organisational conflicts for the AMHP where these can represent 'health and social' terrains (Hemmington et al., 2021) and where failing to maintain one's territory risks deracination (Laing, 1960). Extract 15 also illustrated the ways in which boundaries are relentlessly policed (Sidnell, 2005) and the territories of information are patrolled and regulated in much the same way that ethologists argue that animal territories are (Goffman, 1971; Kamio, 1997).

Opening the assessment

Conversational analytic research considers different forms of openings. The type of opening enquiry can depend on whether there is a deep or shallow epistemic gradient (epistemic access) or, indeed, on the epistemic stance the enquirer may wish to assume. Open-form, general enquiries with an agnostic stance (*What can I do for you today?*) are associated with longer problem presentations and duration of the conversation but are also associated with service user satisfaction. In contrast, closed-form inquiry requests for confirmation (*You're having stomach problems today?)* are based on doctors' knowledge about service users' problems (where there tends to be a shallow epistemic gradient) and, as such, they compel service users to respond with a (dis)confirmation around concrete symptoms. In so doing, they systematically curtail problem presentation and induce a stronger form of self-censorship among service users (Heritage and Robinson, 2006).

In Extract 18, below, the doctor, by asking the service user an open-form general enquiry at lines 11-12 ('*what happened'* and '*what brought you here to the hospital'*) and adding 'in your own words' (line 14) assumes a K- epistemic stance which invites a detailed response:

Extract 18 (AMHP 2):

1 AMHP: So .tch this is Dr ((Name))
2 SU: >Hi pal<
3 AMHP: So Dr ((Name))is go::ing to ask you some questions about
4 your (.) mental health that we (.) we need to be thinking
5 about-
6 SU: [yeah yeah]
7 AMHP: [OK?]
8 Dr: Right .tch
9 SU: COUGH
10 Dr: ((Name)) I (.) em I was ju::st wondering if you can (.)
11 tell me um **what happened** (.) .ttt **what brou:ght you here**
12 (.) **to the .hhh hospital?**
13 SU: [er .hhhh]
14 Dr: **In your own words-**
15 AMHP: [Yes] that would be rea::lly helpful
16 SU: I've been strugg:ling a bit .hhhhhhhh letting everything
17 get on top o' me ummmmmm an' .hhh I .hhhhhhh started
18 drinking hea::::vily for t' week errrr n' .hhh yest:erday
19 morning' .hhh (..) hhhh. woke up (.) .hhhh started drinking
20 then just locked (.) locked t'door >just didn't wanna speak
21 to anybody n mi' girlfriend had to ring't police< .hhhhhhhh
22 then t' police came in (.) in t'house an' said emmmm we
23 can take .hhhhhhh we can take ya under this hhhhh. Section

24 .hhh ummm (.) one three six

Conversely, in Extract 17 above, the AMHP had begun with a closed-form enquiry at lines 1-2 (‘OK so you took an overdose’), thus conveying their knowledge (K+) about the service user and compelling the service user to either confirm or disconfirm this fact, and no elaboration is received. They self-repair this by reverting to an open form general inquiry (assuming a K- stance) in Extract 19, at line 10 below:

Extract 19 (AMHP 1):

1 AMHP: Hiya ((name)) my name’s ((name)) and I’m an Approved Mental
2 Health Professional (.) ummm .hhh as you’ll know you’ve uh
3 seen two doc::tors and they think you ne:ed to be in
4 hospital .hhhh so I need to follow this up to see .hhhh
5 what **we** do
6 SU: (.) ()
7 AMHP: OK (.) OK .hhhh so you took an overdose
8 SU: [Yeah]
9 AMHP: OK so (.) umm (.) so you took an overdose .tch ummm (.)
10 **and can you te:ll me any more about** (.) what that was about
11 (errr)what was .hhhh happening?
12 SU: I aven’t got ma children

Following extract 19, the AMHP and service user achieved some alignment in discussing the events leading up to assessment. Other examples, however, were indicative of diversion and disagreement, explored below.

Disagreement

When service users disagree, they marshal an epistemic resource that is theirs alone - their own experience of how they feel (their K+ position) to express reservations and to seek prompt reconsideration, yet without overtly disagreeing or challenging professionals (Ong et al., 2021). To resolve disagreement and continue with the conversation, professionals can withdraw their prior formulation in order to affiliate with the service user’s position and demonstrate understanding (Muntigl et al., 2013) as in Extract 20, below:

Extract 20 (AMHP 3):

1 AMHP: OK .tch so it ummm it sounds like you’ve been rea:lly

2 concerned about what the .hhh neighbours are doing (.)
3 uhmm .hhh (.)is there umm. .hhh another way of seeing it?
4 Um (.) like they're dril:ling because they need work doing
5 .hhhh and not because they want to put spy holes in the
wall-
6 SU: [No] I don't think that's the ca:se. There's no workmen
7 going in and out (.) No .hhh I think they've got you
8 in on it now then hhhhhhhhhhhhhhhhh.
9 AMHP: OK (.) .hhhh so you're pretty sure that they ar:::e spy
10 holes then an' .hhh there's no other explanation-

Alternatively, speakers can maintain their position in either a convergent and supportive way or a divergent and unsupportive way, implying that the other person's understanding was in need of correction (Muntigl et al., 2013; Weiste, 2015).

In medical interactions, epistemic asymmetries lead to conversational failure when doctors pose questions that conflict with service users' primary knowledge, and service users assert their epistemic rights by taking an independent stand (Lindström and Karlsson, 2016) and epistemic primacy is questioned. This is illustrated in Extract 21 below, where there is a challenge to an assumption within the doctor's question. Here, the doctor requests information in line 1 by using a declarative statement concerning circumstances that are clearly within the service user's epistemic domain *('You've got a lot of suspicion there')* i.e. the epistemic gradient is steep. The format of the question suggests that the doctor is relatively certain of their proposition (assuming a shallower epistemic gradient than actually exists):

Extract 21 (AMHP 3):

1 Dr: **You've got a lo::t of suspicion there**? .tch paranoia?
2 SU: **↓Na:h I don't know** we know each other well hhhh. so
3 Dr: Right
4 (.) errr (.) and are there times that your .hhh thou:ghts
5 get wor::se? More intrusive? Morning? Eve:ning?
6 SU: **I don't know** that they do hhhhhhhhhh.
7 Dr: [Right]
8 AMHP: So .hhh what do you think is the issue ummm with the
9 with .hhh your neighbours then?

The service user says *'I don't know'* in lines 2 and 6. Lindström and Karlsson (2016) refer to 'I don't know' (IDK) prefaces as 'epistemic disclaimers'. It is not actually displaying a lack of knowledge but, rather, signalling interaction problems (and epistemic tensions) that are contingent on epistemic asymmetries between participants. As nonconforming responses, they are resisting something about the question and are thereby presupposing access to knowledge or the rights to knowledge. Their non-cooperative feature may be used strategically to avoid talking about specific topics (Hutchby, 2002).

The service user's response in line 2, '*nah I don't know*,' suggests that there is something about the doctor's proposition that cannot be accepted and it projects a modification. This epistemic disclaimer signals that they are reluctant to accept the doctor's suggested line of reasoning; instead, they are heading toward a more independent epistemic position (Heritage, 2002).

Epistemic primacy becomes an even clearer issue in Extract 22 below:

Extract 22 (AMHP 2):

1 Dr: It sou::nds like you are **drinking a l::ot**
2 SU: Yeah (.) mmm
3 Dr: Ahhh .hhh um .tch **do you nee::d to drink that much**?
4 SU: **No (.) I don't know** .hhhh um sometimes (.)but-
5 Dr: [Have you] been
6 treated for this? Do you get (.) physical problems?
7 **Shakes** (.) .tch **shaking hand**?
8 SU: [Umm (.)]I me:an I have a drink
9 when I've had a long day at work hhhhh.
10 AMHP: OK .hh (.) just tell us about this day (name)
11 SU: [I don't] drink
12 eve::ry day (.)before that I hadn't had a drink for-
13 Dr: [Yes]
14 SU: **I just drink (.) when I feel like it hhhhh.**
15 Dr: mm:m

Earlier in the assessment, the service user reported drinking too much alcohol and this led to the circumstances necessitating the assessment. In line 1, the doctor states that the amount seems large and poses a challenging question in line 3 '*do you need to drink that much*?'. The service user replies in line 4, in a turn prefaced with the particle 'no' (Lindström, 2016), which signals a non-straightforward answer. In line 14, the service user adopts a more definite stand, stating that they just drink when they feel like it. By claiming this, they assume an independent position, claiming epistemic primacy on the issue. There is a later concession that alcohol use is problematic, but at this point the service user is oriented to lay versus professional knowledge (Gill et al., 2001). In doing this, the service user asserts more agency over their response (Stivers and Hayashi, 2010; Stivers et al., 2011 p.22), which may enable them to claim health-monitoring competence (Gill et al., 2001) and, consequently, to avoid detention.

'No-knowledge' *(I don't know*) responses to questions are 'non-answers' in that they fail to deliver the information that the questioner is seeking (Stivers and Robinson, 2006) but explicitly claiming no-knowledge is not the same as providing a non-answer response (Stivers and Hayashi, 2010). Instead, such responses resist something about the question (Keevallik, 2010). Answering with a no-knowledge claim involves re-positioning the questioner from knowledgeable (K+) to non-knowledgeable (K-) or, rather, to knowledgeable of something other than what the question requested. This is how the speaker claims more agency over their response and works toward resolving the epistemic tension in the conversation. They use this to express reservations and seek prompt reconsideration, yet without overtly disagreeing or challenging doctors' authority to diagnose illness (Lindström and Karlsson, 2016). Claiming no-knowledge is a means of dealing with the tension between the biomedical, professional knowledge and the personal, lay experience of health issues.

The question about shakes (line 7) is based on the doctor's professional knowledge; they have made the assumption that this might be a sign of alcoholism. The doctor-service user negotiation on the correct label for the service user's experience manifests itself as a clash between the participants' differing access to relevant knowledge. There is a difference between the doctor's professional experience and superior clinical knowledge (hence the question about alcoholism and treatment) and the service user's access to their own experiences and feelings (K+). It appears that the service user is not willing to accept the full consequence of agreeing with the description 'alcoholism' – a choice of terminology that turns the experience into something pathological, treatable, 'doctorable' and, given the scenario, with potential detention implications.

Repair

So far, this chapter has set out the ways in which conversations have patterns that include trouble points and highlight subtle underpinnings of power. Frequently, significant aspects of AMHP practice were found in the ways in which they use repair mechanisms to enable Empowerment and Involvement and Shared Decision-Making by returning epistemic privileges and primacy to service users.

During conversations, participants commonly encounter problems of hearing, speaking and understanding. When these conversational 'troubles' occur, there is recourse to a 'repair mechanism', or an organised set of practices through which participants edit, rework, address and potentially resolve these problems by seeking clarity (Sidnell, 2010). Speakers actively monitor their recipients for signals of understanding and will change course mid-turn if, for example, patterns of eye contact, facial expressions, or nods suggest something is amiss (Goodwin, 1979; Bavelas et al., 2000).

Repair reflects attempts to achieve shared understanding as they are evidence of the effort a speaker is investing to take the listener's needs into account by preventing misunderstanding and displaying sensitivity (Brennan and Schober, 2001; McCabe et al., 2016). Repair also makes miscommunication visible (McCabe and Healey, 2018; McCabe et al., 2002).

Conversational 'troubles' are various and can include speakers: using the wrong word; failing to find or articulate a word or term correctly; having trouble in hearing and understanding what the speaker has said or what is being talked about; searching for an exact term (where the speaker tends to hold the floor while searching); aborting the production of the term or phrase; replacing a word or similar term (a common type of repair) (Schegloff, 1987; Schegloff, 2007); using silence and delay (which may be produced through 'turn-tokens' to hold the floor such as 'err' or 'uhm' which indicate commitment to continue); using 'repair prefaces' such as preface items like 'well' and 'I mean'; using 'repeats' which are when the trouble source is repeated; and, using 'self-talk', where the speaker pauses and turns to him or herself as if to talk introspectively and demonstrate reflecting on the answer (Kitzinger, 2013).

Extract 23 (AMHP 2):

AMHP: OK .hhhh so (.) um hhhh. can I just ask (.) have you ever
been to ((substance misuse service)) (.) um have you ever
followed that up?
SU: No .hhh .tch I never saw the ne::ed (.) .hh I'm not
a ↑JUN::KIE or owt-
Dr: [But we] are saying that you(.) have been
drink:ing a lot of alcohol recently-
SU: [**Well** yes] but .hhh only
because I 'ad a week off work >I'm not like needing detox
or owt<
Dr: [OK] so so-
AMHP: [**OK so] (.) you don't .hhh think that is a**
problem. £Did you do anything el:se in your week off work?

Here the AMHP asks about the substance misuse service (line 2) but receives a rejection and picks up on disengagement. This is somewhat flagged up by the word ‘well’ at line 8 being indicative of a forthcoming complex response (Shegloff and Lerner, 2009). The doctor continues with the discussion about alcohol, but the AMHP no longer pursues the reflection on alcohol problems and prioritises affiliation and engagement instead (enhanced with a smile voice (£) in line 13). The AMHP observes the service user’s disagreement at lines 4-5, reinforced at lines 8-10, and works to repair the conversation.

Heritage and Robinson (2006) have highlighted the ways in which patients of GP services work at showing that they have the types of problems that warrant medical visits (i.e are ‘doctorable’) and should therefore be taken seriously. They also may be angling for particular treatments (Gill et al., 2001; Stivers, 2002; Gill et al., 2009). Later in this assessment, the service user acknowledges that they do have problems with alcohol, but the extract here illustrates the ways in which service users may downgrade their difficulties (arguing that they are not ‘doctorable’) due to the potential detention outcome. This was the case in two of these assessment transcripts. Sperber et al (2010) make reference to ‘epistemic vigilance’, where participants track what others know and consider the reliability of their claims in order to act on what is being asserted. In this sense, epistemics are a deeply indigenous feature of human interaction, and they are continually at play in terms of power and the privileging of knowledge. Arguably, the AMHP’s attempts to repair at lines 12 and 13 in Extract 23 above represents an effort to privilege a social domain and a shift away from what is ‘doctorable’.

Sometimes, a problem with a turn may not become evident until a response has been received. In the following extract the AMHP realises that their question about informal admission needs to be explained or rephrased because the service user’s response illustrates that they did not understand it:

Extract 24 (AMHP 1):

1 AMHP: You haven’t be:en detained right now (.) so .hhhh I could
2 be looking at hhhh. informal
3 SU: [I’ll go] in informal-
4 AMHP: Do you kn:ow what informal is?
5 SU: (.) It’s voluntary .hhhh where you can just go in when you
6 need it .hhh like (.)
7 AMHP: **I mean** there’s more to it than tha::t (.) you’d be going
8 now hhhh. and they can still stop you lea::ving if they

9 think you're not safe

The use of 'I mean' at line 7 signals upcoming adjustments (Schiffrin, 1987) and the AMHP attempts to clarify the service user's limited understanding as to what to expect from an informal admission.

In the following example, the AMHP repairs a misunderstanding between doctor and service user in terms of a fundamental conceptualisation of illness:

Extract 25 (AMHP 3):

1 Dr: You have schizophrenia .tch and this .hhh this means that
2 the medication will balance (.) the disturbance in your
3 .tch .hhhh thinking-
4 SU: [I don't] know .tch >I don't see how
5 popping chemicals is a good idea<
6 AMHP: It's .hhh um not always about chemical imbalances (.) hhh.
7 sometimes problems and um setbacks ca:n be related to other
8 things like not sl::eeping or stress (.) .hhh have you
9 b::een under stress lately?
10 SU: [Oh yes] (.) DEFINITELY what
11 with the fu:neral and hhh. that

Overall, repair displays how participants work to maintain interaction. It is in this sense that Schegloff (1992) describes it as the primary site of intersubjectivity in conversation. The more frequent the examples of repair, the harder people are working to establish mutual understanding. In many areas of the transcripts from this study, AMHPs were observed repairing conversation (including with self-repair) and these repairs were often intertwined with hearable displays of empathy.

Empathy

In mental health settings, communication between service users and professionals is particularly problematic due to a lack of shared understanding about the problem. This includes a lack of consensus regarding conceptual factors such as whether difficulties are 'symptoms' of an 'illness', and consequent ideas about causes and treatment (Jaspers, 1959; Watzlawick et al., 2011). The meaning of 'symptoms' is regularly disputed, with service users experiencing them as real and clinicians attributing them to an illness and psychiatrists feel challenged by not wanting to collude or confront service users' beliefs (McCabe and Priebe, 2008). In the following extract, the doctor is asking why the service user's GP requested the assessment:

Extract 26 (AMHP 3):

1 Dr: So .tch why did ((GP name)) ask us to (.) s::ee you?
2 SU: I just said to her hhhh. that .hhh the neighbours were
hhhh. nosey and spi:ed on what we did hhhhh.-
4 Dr: [Hmm OK] and .tch and
5 what um what (.) did she think?
6 SU: >She said that's because I'm I'm not well **am I**?<
7 Dr: **we::ll that's possibly right .tch yes-**
8 SU: [↑Oh and] you'd know it
9 all already #wouldn't you? Hhhhhhhhhhhh.
10 AMHP: Um hhhh. **so you're worr:ied about** the neighbours (.) then?

At line 6, the service user comments on the GP's opinion using a downgrading tag question (*am I?*) to downgrade this belief about illness. The doctor then agrees with the illness explanation (line 7) '*well that's possibly right yes'*, overtly confirming the GP's belief and assuming epistemic authority by evaluating it as correct. At line 10 the AMHP attempts to repair this, by acknowledging the service user's beliefs and epistemic privilege.

In the conversation below, the AMHP has arrived on their own to assess a service user in A and E, who was brought in by the police. The service user believes that she has already been detained and the AMHP's *Oh*-prefaced response (at line 13) is used to express surprise at this. Responses such as this can act as a form of epistemic push-back, or to assert epistemic independence (Wilkinson and Kitzinger, 2006) and priority over the doctors. However, the assertion made by the service user at lines 11-12 ('*I don't need to be sectioned'*) appears to deeply intrude into the AMHP's epistemic priority as regards the decisions that the AMHP is entitled to make as a matter of law. The AMHP asserts their epistemic sovereignty at lines 13-14 ('*well that's something I need to decide'*) over the application of statute (Heritage, 2013). The AMHP also uses their epistemic domain and responsibilities, where whether the service user needs to be detained lies within the AMHPs territory of knowledge.

Extract 27 (AMHP 1):

1 AMHP: umm now the doctors that saw you .tch err earlier this
2 morning err .hhh th (.) they felt that you uh p (.)
3 perhaps may benefit from a .hhh short admission um

SU: [yeah but]
they didn't say (.) they just sa::id section two's
until you go in .hhh informal >cos if they'd have said
would (.) would you go in informal I'd have said yeah<
AMHP: OK do you think .hhh you you would go in inf (.) if .hh
if my outcome today is that you would go on an hhhh.
informal basis
SU: [Yes] fine I'll go in informal hhhhh. ↑**I don't**
need to be sectioned
AMHP: ↑**Oh** (.) OK you don't need to be detained (.)OK .hhhh **well**
.hhhh **that's something I need to decide** (.) .hhhhh and do
you understand what informal is?

During this conversation, both speakers are still addressing the terms of agreement (Heritage and Raymond, 2005) and the questions of epistemic priority and of 'who is agreeing with whom' is being established. Here, the AMHP has maintained their position in a relatively divergent way, implying that the service user's understanding was in need of correction (Viklund et al., 2010; Muntigl et al., 2013; Weiste).

In the following Extract (28), the doctor, AMHP and service user are discussing the overdose of Oramorph[29], starting with how he would not normally use acts of self-harm:

Extract 28 (AMHP 2):

SU: but I wouldn't normally d:o that stuff
Dr: [so I] guess uhhm
that's one of the the things I (.) wonder about uhhmm is
.hh do you think the .hhhhhhh drinking and the uhhmm the
(.)overdose are umm related (.) do you think?
AMHP: **uhmmm yeah** I wonder if if (.) **((Name)) might be able to**
tell us?
SU: hm yeah yeah (.) I .hhhhhh think it was the stress umm
y'know work and that-
Dr: [so how] much Oramorph did you take?
SU: Uhhmmm .hhhh not sure
AMHP: [so **I'm] guessing** it was hhhh. **kinda** worse

---

[29] Oramorph is a morphine-based painkiller, dangerous in overdose.

13 this particular day ummm because of work (.) **was it?**
14 SU: [yeah]
15 yeah it had built right up

In this extract, the absence of explicit agreement about whether the service user's overdose was due to substance misuse is displayed through silences. The AMHP addresses this by directing the conversation towards the service user and their primary epistemic rights and authority at lines 6-7. The AMHP's use of '*I'm guessing'* (line 2) is also speculative, rather than interrogative, and as such is associated with low entitlement and high contingency (Curl and Drew, 2008; Schriver et al 2019) and a downgrading of epistemic and deontic authority (Ong et al., 2021). The subject change at lines 12-13 also highlights where the AMHP is returning epistemic authority and involving the service user by topicalising their earlier response to the conversation about work stresses.

At line 6, the AMHP's response does not include an explicit agreement with the doctor, evident through the use of '*uhmmm yeah'* which acts as an 'acknowledgement token' but does not precisely conform to the expectations set up by the doctor at lines 2-5. Instead, they are diluted or neutral receipts where the AMHP is 'on the fence' and not providing straightforward agreement or judgement but, rather, a downgraded authority, certainty and commitment. Acknowledgement tokens such as this are not treated as conversational detritus but, rather, they serve a purpose.

At line 12 the use of the modifer (*kinda*) downgrades the certainty of the statement (Peräkylä, 1998) and the ending of the sentence with the tag question (*was it?)* (line 13) offers a shared understanding and an invitation for the service user to confirm it (which he does in lines 4-5) (Heritage and Raymond, 2005). The AMHP has invited the service user to be a co-assessor and someone who is capable of observing and drawing conclusions from what had happened, and the conversational pattern validates the service user's involvement (Land et al., 2017).

Displays of emotion are also handled in ways that are more or less empathic. Ruusuvuori (2005; 2007) and Hepburn and Potter (2007) consider two types of responses to displays of upset: those that give callers 'permission' for their emotional displays (such as crying) before continuing the delivery of information ('take-your-time' expressions or TYTs), and those responses that are empathic (ERs)[30]. These are illustrated in the following extract:

---

[30] They use Suchman et al's (1997) definition of empathy where empathic communication entails the accurate understanding of the person's feelings and the communication of that understanding back to the service user in a way that they feel understood.

Extract 29 (AMHP 2):

1 Dr: And (.) .tch (.) you have been working in the army is that
2 right?
3 SU: yeah .hhhhhhh yeah
4 Dr: And I have been umm looking thr::ough the notes and there
5 is some mentions of .hhhh PTSD can you te:ll me (.) hhh.
6 wh:at is that?
7 SU: It's just (.) .hhhh ↓memor:ies .hhhh obviously what I saw
8 hhhh. you see what you see-
9 Dr: [could you] tell me-
10 SU: [It's] very close to
11 my heart-
12 Dr: [Uhhh] **maybe alcohol makes this worse?**
13 SU: .hhh hhh. (.) **yeah maybe** (.) **#dunno**
14 Dr: [Mmm]
15 SU: .hhh hhh. .tch #Um (.) hhhhhhhh.
16 Dr: OK hhhh. **OK do you want a minute.**
17 SU: ((becomes visibly upset)) ()() ((sniffs))
18 AMHP: You so:und as though you are **quite upset now.**
19 SU: hhhhhh. **Ye:ah** (.) I mean I suppose you have to ask .hhh
20 (.) n' maybe it's part of t'problem.

At line 12, the doctor delivers advice and attempts problem-solving and this is received with initial silence, followed by a minimal acknowledgement of the advice but with no display of affiliation with it – a '*yeah maybe'* receipt at line 13. At the end of line 13, '*dunno*' is indicative of disaffiliation and a failure to follow the moral order of sobriety. There is a TYT response at line 16, to no effect, and the empathic response is located at line 18 which has a greater effect. The empathic response occurs after an advice sequence where the advice has not been received by the service user with an adequate response and the institutional task of the assessment and problem solving is stalled. The empathic response contains a formulation of the service user's mental state; '*You sound as though you are quite upset'*, and also a marker of the contingency of the ascribed mental state of the service user; '*you sound as though'*. This formulation has an epistemic dimension to it: the AMHP treats the service user's mental state as something the service user has primary rights to know about (they have a K+ status). With the formulation 'You sound as though', the AMHP locates the evidence for topicalising the service user's emotional state in their voice. This obligates the service user to confirm or disconfirm the AMHP's understanding, and the confirmation ensues at line 19.

Empathic responses recognise the service user's distress with a formulation of their mental state and, simultaneously, their ownership of this knowledge, thus acknowledging their right to assess their own mental state and prompting them to elaborate on their feelings of distress (Perakyla, 1995). As such, they are more effective in forwarding the conversation, and in involving the participants, than are TYT responses.

Affiliation, non-affiliation and alignment

Affiliation is a means for displaying alignment and the terms have been used interchangeably (Steensig and Drew, 2007). However, professionals will often prioritise the collection of facts and problem-solving over affiliating. Affiliating responses are therefore ones which address the problematic experiences of the service user, rather than orient to the activity of problem-solving (Ruusuvuori, 2005; 2007). Epistemic access plays a role in both promoting and displaying affiliation (Pomerantz, 1984).

The extract below (30) provide examples:

Extract 30 (AMHP 2):

1 SU: I've been strug::gling a little bit (.) .hhh um not feeling
2 right n. .hhhh letting everything get on top o' me ummm
3 .hhh again n' I started drinking .hhh **hea:::v::ily** for the
4 we:ek ummm (.) n' yesterday morning' .hhh woke up
5 (.).hhhhh started drinking **heavily** umm hhhh. then just
6 locked (.)locked the door (.) just (.) ↑didn't wanna speak
7 to anybody (.) > ma' girlfriend 'ad to ring t'police
8 to get in t' 'ouse n' then the police said emmm we can .hh
9 take (.) we can take yer under this section< .hhhh one one
10 three six-
11 Dr: [How have] the police got involved-
12 SU: [I think] ma' girlfriend
13 (.) .tch (.) or one o' ma' neighbours called 'em.
14 Dr: Mmm .hhh you're not (.) sure you know who called them.
15 SU: N::o
16 Dr: [Your girlfriend lives with you?]
17 SU: [yeah (.)yeah]

18 AMHP [mmmm]
19 Dr: [So] (.) so on that day
20 you **kicked her out**? Or what?
21 SU: **[>↑NO<** (.) No she'd] gone into work
22 Dr: [OK] right I see
23 SU: [so I]
24 tho:ught it was gonna be a good idea to .hhhh start drinkin'
25 first thing in't morning (.) .tch (.) to hhhh. try to chill
26 out like
27 AMHP: **[hhhmmmmm] (.) uhh huhh**
28 Dr: [And how] much were you (.) drinking?
29 SU: Ummm well not hhhh. Not-
30 AMHP: [**Right**] (.) >**So you fe:lt as though things**
31 **had got on top of you and life was a bit of a struggle that**
32 **day?<**
33 SU: >**Yeah yeah** totally<

Stretching the word 'heavily' (at line 3) and repeating the word (line 5) upgrades the severity of the problem and strength of feeling (Lindstrom and Sorjonen, 2013). At line 21, at the suggestion that the person 'kicked out' his partner, they respond with 'no!' with a pitch shift (Hepburn and Bolden, 2013) where elevated pitch is often associated with heightened emotion (Ruusuvuori, 2013). At lines 30-32 the AMHP displays affiliation by developing the description that the service user began with: '*So you felt as though things had got on top of you and life was a bit of a struggle that day*?' The service user receives the response with affiliating *yeah*-particles (line 33) and, following the AMHP's request for confirmation, corroborates the AMHP's interpretation of the state of affairs they are describing. At line 27 the AMHP is using aligning actions through (*Hmmm* and *uh huh*) which indicates their pro-social character which is supportive of social solidarity (Stivers et al., 2008; Lindstrom and Sorjonen, 2013).

At line 30, the AMHP closes the question and examination sequence with '*right*', which starts a new activity and indicates a taking over of the conversation. The AMHP identifies the service user's first statement (lines 1-2) as a 'troubles-telling' (Jefferson, 1988) (*not feeling right; everything getting on top of me*) and they do not turn to problem-solving at that stage (lines 30-32).

Finally, at lines 30-32, the AMHPs use of the so-prefaced declarative question (*so you felt as though things had got on top of you …*) contain 'B-event information' (the service user's psychological state) characterised by the ‘known in common’ (Heritage, 2012) epistemic authority of the service user. By doing this, the AMHP creates a slot for the service user to display alignment by (dis)confirming, which they do at line 33.

In Extract 31, below, the AMHP orients to fact-finding at the expense of an affiliating response:

Extract 31 (AMHP 1):

```
1  AMHP:   OK (.) .tch so you took an overdose (.)so you took an
2          overdose of-
3  SU:     [sixteen] co-codamol
4  AMHP:   Okay (..)hmmm a:nd (.) and why was that? ((name))?
5  SU:     hhh. to try and kill me’self
6  AMHP:   Ok:ay (.) yeah (.) and .hhh why would you hhh. want to
7          kill  yourself?
8  SU:                [I’ve] not got mi’ children (.) .tch mi’
9          life’s shit.
10 AMHP:   Okay (.) mmmm (.)and where are your children?
11 SU:                                            [adoption.]
12 AMHP:   Adoption? Okay .hhhh so when you ca:me to ummm hospital
13         .tch did you have any expect::ations? About the outcome?
14 SU:     ().tch (.) dunno (.) whatever
```

As noted above, the response tokens of ‘mm’ and ‘yeah’ can be agreement markers but when combined with quieter volume, lack of emphasis and silences (as in the extract above) they can instead simply suggest acknowledgement (Pomerantz, 1984). The AMHP was using these agreement markers whilst taking notes and, as such, they may be less of a sign of active listening and more of an opportunity to take up the content of the previous turn of talk, thereby displaying avoidance rather than active listening (Jefferson, 1993; McCabe et al., 2002).

The extract below illustrates ways in which language can be ‘psychiatrised’ and, in the end, the AMHP returns the floor to the service user:

Extract 32 (AMHP 3):

```
1 Dr:      And how have you been slee::ping? Are you sleeping well?
2 SU:                                                [I think so]
3 Dr:                                           [Or not so well?]
4 SU:      Umm .tch well there are times when I’ve (.) .hhh struggled
5          to get off and-
```

6 Dr: [and] what about wa:king up in the morning?
7 hhhh. Earlier?
8 SU: [we:::ll] I keep getting woken up by people
9 .hhh outside the house and next door (.) n' >this is the
10 first thing I need to sort out and I'd rather be gettin'
11 back to check that nothin's been touched like-<
12 Dr: [OK so] you
13 still have some .hhhh para:noia around the people hhhh.
14 next door (.) .hhh and what about eating? Loss of appetite?
15 Anything like that?-
16 SU: (3.0) [errr] no I don't think so-
17 Dr: [And have you] been
18 hearing any voices?
19 SU: .hhhh well as I s::ay the sounds from next door were
20 bothering me .hhhh and I need to know what the score is
21 there-
22 Dr: [OK] and **going forward** are you planning to take the
23 Quetiapine?
24 SU: () [.tch] .hhh errr
25 Dr: [Because **going]** **for::ward** we need to be
26 deci::ding what we are going to do to (.)umm
27 sta::bilise here as I .hhhh it looks from what hhh. what
28 you say that you are .hhhh still having (.) paranoid
29 thoughts and some .hhh overvalued ideas?-
30 SU: () [.tch] (.) **I don't**
31 **think** I am (.) I think .hhhh ummm I don't think you-
32 AMHP: [**OK]** **.hhh**
33 **I think** (.) **what do you want ((name))(.)what would you**
34 **choose for .tch yourself?**

At lines 22 and 25, the doctor's use of '*going forward*' acts as a 'pre-closing' device (Beach, 1995) to avoid the service user's elaboration (Beach and Dixon, 2001), and as such it also deletes the service user's prior answers and concerns. At lines 8-11 and 19-21 the service user is attempting to discuss their concerns about their neighbours, which is at the root of the request for a MHA assessment. At lines 12-13, the doctor has picked up on the service user's concerns, edits and replaces them with their own interpretation and psychiatric frame of relevance (Beach and Dixon, 2001; Depperman and Fogasy, 2011). They return this to the service user as ‘*you still have some paranoia’.* The so-prefaced ‘*so you still have some paranoia’* also condenses a longer stretch of talk where the service user is explaining their concerns. The doctor simultaneously distils (and thereby deletes) the extensive material provided by the service user into an overall general sense or ‘gist’ (Heritage and Watson, 1979), but then summarises the service user’s description into a diagnostic framework and label (Johnson and Cotterill, 2002). The significance of the service user’s narrative and epistemic status is diminished.

At line 16, there is a long pause before the service user speaks. Silence can convey disagreement and risk social solidarity (Ong et al., 2021) and they place pressure on a recipient to respond (Stivers and Rossano, 2010). Generally, remaining silent in the face of another’s question is extraordinarily difficult and the unsaid accomplishes two things: (1) it enables the participants to pursue their conflicting agendas without the conflict rising to the surface of the interaction and (2) it keeps the possibility of a psychiatric diagnosis off the record (Toerien and Jackson, 2019).

At lines 30-31, the service user articulates disagreement (*I don’t think …)* with the recasting of their contribution within a psychiatric frame of reference and, at line 32, the AMHP picks up the disagreement with an attempt at repair and rescue. *‘OK’*, at the start of the talk, acts as a receipt token which can also be used as an upcoming change of activity (Gardner, 2001). The AMHP is also attempting to topicalise and prioritise the service user’s concerns and to restore epistemic symmetry and, further, asking ‘*what would you choose for yourself*’ (lines 33-34) acts as a form of empowerment.

The doctor’s drawing on jargon through medical terminology and authority (using words such as ‘*paranoia*’ at line 13 and ‘*stabilise*’ at line 27) are examples of the ways in which communication and its frame of relevance are shaped by the professional identities and setting (Drew et al., 2001). Antaki (2008) suggests that the ‘common thread’ of formulations is that the doctor, as institutional agent, has ‘plucked’ out something in the service user’s words and presented it in terms of institutional or professional interest. The AMHP, however, has embedded and applied their professional imperatives to shift the conversation back to the service user’s domain thereby involving them in the conversation. At line 33, the AMHP’s ‘I think’ presents their own perspective whilst introducing a downgraded certainty and lack of commitment (Kaltenböck, 2010; Stevanovic, 2013), and they finish the talk with a rising intonation and a question to return the floor to the service user (Stivers and Rossano, 2010).

At lines 33-34, the AMHP asks the service user ‘*what do you want … what would you choose for yourself’* which involves the service user and invites them to make a proposal for a course of action that would address the difficulties. Using this information-soliciting question, the

AMHP claims lesser epistemic and deontic rights than the service user and provides an opportunity for the service user to draw upon their own knowledge of the situation in order to generate an idea. Thus, they give the service user the right to make the initial proposal and to be actively involved in the decision-making process.

Professionals have authority by virtue of their institutional and legal status. To promote a collaborative approach, they need to work at downgrading the authority connected with their position (Guilfoyle, 2003). The conversational preferences to provide agreement and maintain sequence progressivity and social solidarity (Sacks, 1987; Pillet-Shore, 2017) does not always fit easily within MHA assessments and their multiple perspectives. Eliding agreement may be a way of fulfilling opposing demands as by avoiding explicit disagreement, professionals can avoid undermining each other's authority in front of the service user (Ong et al., 2021).

AMHPs' presence and visibility in MHA assessments

AMHPs have described their lack of visibility and tensions around allyship in assessments (Hemmington et al., 2021). In the extract below, the service user is displaying an interpretation of whose 'side' the AMHP is on. They do not use the expected neutral referent '*the* doctor' or 'he/she' and, in so doing, they are doing more than just referring:

Extract 33 (AMHP 3):

1 AMHP: I'd like to know what you think (.) .tch .hhh do you think
2 you need to (.) be in hospital?
3 SU: well .hhh **£yer do:ctor** there seems to think so.
4 AMHP: OK **((name))(.)**I'm hear:ing that you don't agree with this?

In using the alternative recognitional (Stivers, 2007) *'yer doctor'* (line 3) the service user is demonstrably associating the AMHP with the doctor rather than with themselves. As a 'marked' form of reference, this can be an act of provocation and is similar to the classic 'look at what *your* son has done now', used to explicitly associate the referent (the parent) with the aberrant son. The referent becomes 'responsible for the complainable action' (Grice, 1989 p,78).

At line 4, the AMHP uses the person's name to personalise and register the concern as their problem, thereby attempting to realign. The AMHP simultaneously tries to downgrade both their own deontic and epistemic authority through the phrase '*I'm hearing that'* (Muntigl and Horvath, 2020). Here the AMHP is deferring and conveying respect to the epistemic authority of the service user as well as attempting engagement and social solidarity. The AMHP is forgoing the opportunity to present their interpretations as objective facts and mitigates the implication of superior claims to knowledge about the service users' experiences (Ong et al., 2021).

Paralinguistic features: laughter

One paralinguistic feature of conversation is laughter. This can be used to develop and maintain rapport with others and humour, often rooted in ambiguity, can be used in non-humorous contexts to stimulate problem-solving, search for explanation or to work at finding resolution (Lamptert and Ervin-Tripp, 2006). In Extract 34, the AMHP is concerned that the police's actions were problematic and a potentially unlawful breach of the person's legal rights. The laughter at the end of their turn at line 34 is recognising that it is troublesome rather than humorous and they offer to advise and provide advocacy at a later stage.

Extract 34 (AMHP 2):

1 Dr: Did they ((the police)) .hhh explain to you why .hhh why
2 they had taken you to the (.) hospital?
3 SU: .hhhh 'cos apparently ((girlfriend's name)) thought that I
4 might be a danger to m'self .hhhh >which I never would have
5 been< emmmm (.) .tch (.) and then they had the rights
6 to do that ehhh (.) .tch (.) ehh take me up to the
7 hospital (.) ehhh (.) under that section-
8 AMHP: [Just] out of
9 interest .tch did th::ey take you straight from your house?
10 Up to the hospital?-
11 SU: [Yeah] they got a (.)ambulance (.) But ma'
12 partner were (.) like I say (.)sent me up to t' 'ospital-
13 AMHP: [OK]
14 were you happy to do that?-
15 SU: [Yeah] (.) yeah
16 AMHP: [You didn't] mind going
17 to get checked out?
18 SU: No no.
19 AMHP: OK (.) .hhh and did (.) did they explain to you (.)if
20 you were going happily with them (.) .hhh why they wanted
21 to .tch put you on a one three six? From inside your home?
22 SU: .hhh (.) I'm not su::re to be honest (.) I were just sitting
23 in £mi'pants watching teevee and that (.) >and the next

24 thing the fuc .tch sorry love< the police are staring at
25 me like-
26 AMHP: **[Oh::] wo:w (.) Ohhh Go:d**
27 SU: .hhhh ummm hhhhhh.
28 AMHP: [I'm a bit] unsu::re about how that hap:pened to be
29 honest .hhh I mean (.) it so::unds like it's all worked
30 out ok::ay 'cos you didn't mind getting .hhh checked out
31 (.) but I .hhh err (.) I don't think they (.) should have
32 told you you had to leave your house with them (.)but (.)
33 that's .hh that's something £we can £we can you know .hhh
34 talk about afterwards heh **heh heh** ye::ah **heh heh heh**
35 SU: Oh?

At line 26, the AMHP displays response cries (*Oh wow; Oh God*) which Goffman (1981) describes as responses with minimal lexical content and they serve as a resource with which the second speaker can fully affiliate with the experience the first speaker has reported. They 'evoke and claim a degree of empathic union and affiliation between teller and recipient' (Heritage, 2011 p.176). In this case, the AMHP is orienting to a professional advocacy and justice-focused approach.

Closing the consultation: Some or Any

Patterns are found in the closing of conversation. Whether or not service users reveal hitherto unmentioned concerns is strongly associated with how the doctor asks the question (Heritage, 2018). The word 'any' has a closing-down function, whereas the word 'some' is positively polarised. When doctors ask 'is there anything else …' the most common response is 'no' – even though they had established that patients did have further concerns. The word 'any' is negatively polarised (tilted towards a negative outcome) and, therefore, projects that there won't be problems and leads to a 'no', whilst 'is there *some*thing else?' is an invitation to a 'yes' and a sharing of new symptoms (Heritage, 2018).

Extract 35 (AMHP 2):

1 Dr: I think we know all we need to know .hhh now and we ne::ed
2 to ma:ke a decision about what happens (.)next in terms of
3 umm treatment and so on (.) .hhh do you have **any** thoughts
4 on this?
5 SU: Errr no (.) not really-

6 Dr: [Is there] anything you would like to ask?
7 SU: Errrr no
8 AMHP: Please give us a few minutes (.) and we will come back and
9 .hhhh let you know what we think

Not only is the doctor closing the assessment at line 1, by asking the service user (as lay person) whether he has '*any'* thoughts about the matter (line 3), he also is enacting and asserting expertise by the use of the negative polarity item 'any' (Heritage and Robinson, 2011). It delivers an expectation that the service user will be unable to construct an answer and it discourages them from articulating it, even if they can (Raymond, 2003). It projects knowledge, specific identities and elements of power (Bourdieu, 1985). It also echoes Kamio's (1997) 'territories of information' wherein interactants have a relative 'knowing' and 'unknowing' status about the subject.

Significantly, and a point returned to in this study, this is also the point at which, in all three assessments, the assessors retired to another room to undertake their decision-making.

Chapter summary and close

This chapter highlights the ways in which professionals can assert and uphold the power of the system, or where they might use their professional selves and communicative techniques to enact and embody an empowering approach. This is the first time that research has explored these important, usually private, encounters at which service users' liberty is at stake in a MHA assessment.

AMHPs have overall responsibility for coordinating MHA assessments. This is generally understood to mean the practical and processual aspects of the work, for example arranging for assessors to arrive at the same time or arranging transport to hospital. Yet findings from this chapter indicate that coordination extends into the assessment itself and that this should be considered to be a deliberate and deliberative part of the work.

Social epistemics, or the ways in which participants handle knowledge distributions among themselves, is key to an understanding of empowerment and involvement. Mental health service users have described a 'them and us' experience (Barnes et al., 2000) and this is precisely to do with different epistemic communities (in terms of identities, beliefs and knowledge) that go unchallenged. There was evidence in this chapter that AMHPs worked to downgrade the authority connected with their position and, at times, through a deliberate use of repair, worked to restore social solidarity through their communicative actions. Whether or not service users were empowered or involved was inextricably linked with their perceived epistemic rights (rights to knowledge) and their deontic rights (their rights to determine future action).

Groups or individuals' different epistemic domains, 'territories of knowledge' (Labov and Fanshel, 1977) or epistemic stance (knowledge and beliefs) are apparent through their communication. At times, AMHPs were alert to this and would seek to repair conversations between doctors and service users to achieve a more equitable horizontal playing field. Conversational analytic literature suggests that professional and service user interactions are characterised by asymmetries that are created through the differences in roles, knowledge bases and expectations (Drew, 1991). The doctor is the expert who possesses formal biomedical knowledge and authority whilst the service user has a social and personal lay perspective (Lindstrom and Karlsson, 2016). The analysis in this chapter, for the first time, began to ask salient questions and explore the AMHPs' position.

AMHPs are, by design, intended be independent from medical perspectives. They have a middle-ground, liminal position. Findings from this chapter highlighted their shifts in affiliation and alignment with service users' direct, first-hand knowledge of their own experience and with doctors' greater knowledge of medical symptoms and their causes. AMHPs did evidence empowerment, however, in the way that they restored epistemic primacy to service users who they viewed as being entitled to their subjective experience and having a right to communicate it. AMHPs displayed alignment with service users through the use of empathy and the ways in which they returned the floor (or returned the voice of the life-world) to service users.

AMHPs balanced power in different ways. Doctors have authority to decide what is relevant in terms of diagnosis and treatment, but AMHPs have authority to make an overall decision about detention. Interestingly, what came to the fore at different times for AMHPs in their decision-making gave a window into their priorities (social needs, risks and service users' rights). AMHPs were seen to defend their territories, conflict with and stand up to doctors (AMHP 3) although they may also defer to doctors (AMHPs 1 and 2) at different times.

AMHPs addressed aspects of deontic status (relating to participants' rights to determine their future course of action or 'how the world ought to be') (Stevanovic and Perakyla, 2012). This, essentially, pertains to the maximisation of self-determination.

Overall, applying Conversation Analysis to MHA assessments enabled a greater understanding of the actual *doing* of the work, moment-by-moment and this allows those involved to see what is happening. The following chapters turn to the perspectives of individual participants: the interviews with AMHPs and people with lived experience of the assessments. This enables a greater understanding of MHA assessments in terms of the ways that they are experienced and interpreted by those involved.

Chapter Seven: Interviews with AMHPs and Service Users Data Analysis and Findings

Following the Mental Health Act assessments, I undertook and audio-recorded interviews with the AMHPs involved in the assessments. I then went on to interview the three people who had been assessed and these interviews took place between one and three weeks following the assessment.

I outline these interviews below. Due to my concerns about sample size my data is supplemented with analysis and discussion from the findings from a re-interrogation of a set of data from a national research project I led from January to May 2021 (Hemmington et al., 2021) in which the research questions and methods overlapped with the current study. This project was commissioned by Social Work England (the regulatory body for AMHPs) to enable them to understand more about the AMHP role as it is experienced by both AMHPs and (as presented here) people with lived experience of MHA assessment and detention[31]. For this latter study, fourteen people with lived experience were interviewed, and all consented to my re-evaluating the data for the specific purpose of this study.

Figure 9 below summarises service users' from the national research project's backgrounds.

Gender	Age ranges	Experience
7 male 7 female	1 under 20 2 20 to 30 5 30 to 40 3 40 to 50 2 50 to 60 1 over 60	1 assessed once 9 assessed 2-5 times 2 assessed over 5 times 2 can't remember

Figure 10: National research project service users' background details.

Transcripts were developed from all interviews and Thematic Analysis (Braun and Clarke, 2006) was used to analyse the data. Superordinate and sub-themes were identified, and these are set out thematically in Figure 6 below, with quotes to illustrate the different areas[32]. Proceeding from this analysis of pooled data, as would be expected, many themes are common to both studies. I highlight where some are unique to one or other of the studies.

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[31] This is hereafter referred to in this chapter where relevant as 'the national study' to distinguish it from my local research project for my doctoral studies.

[32] Appendices 6-8 provide an outline of the themes together with the key points dealt with under each theme.

Power, Authority and Coercion	Professional autonomy and power Power and Coercion: Service users' experiences
Autonomy and Independence	AMHP role in current practice Visibility Decision-making
Social Perspective	Models and theories In practice
Organisational Issues	Interdisciplinary challenges Resources 'Time' as resource
Emotions, stress, health and burnout	Moral injury Support Ambivalence Self-mortification
Democratised practice and relational work	Communication Relational practice Shared Decision-Making Empowerment and Involvement Kitchen Conversation
Job fulfilment	Power in the role Variety Advanced skills Relationships/emotional connections

Figure 11: AMHP and Service User Interview Themes

Power, Authority and Coercion

Power, authority and coercion are key themes. Interestingly, manifestations of power (and control) were apparent in different ways. AMHPs’ relationships with doctors are discussed, particularly with respect to their autonomous role (and its perceived undermining). Service users described their experiences of powerlessness and coercion as well as a sense of fatalism, evaluated later as an antithesis of empowerment, involvement and Shared Decision-Making in MHA assessments.

Professional autonomy and power: AMHPs

For AMHPs, there was a greater tendency to be motivated by, and to even thrive on, challenges with other professionals where a more combative or adversarial style was apparent:

> *The power thing is often there, especially when you're working with different doctors and establishing the terms … you know jostling for position … I think we've all been there where sometimes you throw something in just out of … pure buggeration, just so they know you're your own person here and have a say… you know, independent … (AMHP 3)*

> *Sometimes it's like a game of 'top trumps' where you believe your take [social perspective] is worth more so it's the one you're going with, and you win. (AMHP 2)*

This seemed consistent with the idea that AMHPs use their power 'as a tool for good' in MHA assessments to minimise the influence or dominance of the 'medical model' (Rabin and Zelner, 1992; Colombo et al., 2003; Morriss 2015; Buckland, 2014; Hemmington et al., 2021). It illustrates their beliefs about the importance of retaining their independence within these multidisciplinary power struggles.

The motivation for this apparent attempt to use power and authority for good was expressed as being part of a sound moral order and borne of the AMHPs' aspirations for advocacy and the upholding of a rights-based approach. It is also an articulation of the early statutory intention that AMHPs' duties and powers are not intended to be subordinate (DoH,1993). It seems consistent with AMHPs' apparent propensity to act as a 'brake' on clinicians' decision to detain (Peay, 2003) in keeping with pursuing a level of least restriction within the guiding principles to the Act (DoH, 2015).

There was evidence of AMHPs' professional, or even personal, value base leading them to act with a 'higher authority than the law' (Peay, 2003 p.46). This approach, only tacitly and infrequently referred to in the literature, was apparent where one AMHP said they would:

> *… only go out once a bed is available. I know it's not legal but … If there is no bed, there's no point in you going and causing distress. The law is interpreted differently. (AMHP 1)*

This point is reminiscent of Peay's (2003) research whereby one ASW stated that they 'are not in this business to be legal' (p.19) but, here too, AMHPs appeared to be saying that the professional value-base, advocacy and concern for service users' distress took precedence – again indicating that the AMHP role is more than a legalistic one. The national bed shortage (NHS Digital, 2022) is being factored into AMHPs' decision-making and to some extent they are attempting to reconcile their role (and value base) with this relatively new problem and the widening gap between need and resourcing. It is also reminiscent of Machiavellian activities where the imperfect nature of the world leads actors to use means that would generally be regarded as bad, in order to pursue ends that are good (Denzin, 2010).

This same AMHP articulated a belief consistent with the idea that the 'best personality type' for AMHP work is to be 'strong, assertive and able to challenge doctors' (Morriss, 2016 p.714). Below, they outline a scenario conveying anger, resistance and the need to 'tell a doctor off':

> *I wouldn't have done this in [my] first 12 months, but I told a s.12 doctor off … They said 'she's coming in [to hospital]' during the assessment and got her medical recommendation out and that pissed me off. [The service user] didn't meet the criteria and the second doctor agreed with me … she was a new SPR … and the first doctor said 'you should be making a med rec'. You cannot influence another doctor and they were bullying [the second doctor] to complete it and she gave in which annoyed me. I didn't make the application so no detention … It's a power thing like 'what the fuck do you know, you little AMHP'? (AMHP 1)*

The apparent feelings of attack (and anger arising from this) on the AMHPs' autonomy and position as applicant (i.e final decision-maker) is clear. This appeared to be related to power relations between them and the doctor, but again there are aspects of advocacy: the anger arises from the doctor telling the service user that they are going into hospital before the AMHP's decision is known to them (and the AMHP disagrees with the need for detention). This is the same AMHP who, above, is prepared to interpret the law and potentially act in a way that is 'not legal' as their values-led practice appears to be at the forefront of their decision-making. It is also noteworthy that AMHPs' references to, and observations of, underlying power rests on relations with their professional colleagues, with observations of power relations between themselves and the person they are assessing being less apparent. People with lived experience of being assessed had a different viewing point.

Power and coercion: People with lived experience

From my own study, when asked what, if anything, sticks in their mind from a MHA assessment, for people with lived experience it was the enormity of the experience and their lack of power and agency therein. Some of this arose from the rules and rituals associated with the magnitude of formality, bureaucracy and associated peril:

> *Just how big it is. And how much of a fine line it is. I never had any idea that it could be so easy to end up being banged up. How formal it all is – like all of a sudden it got real, and everyone was there with their badges on talking about the law and detentions and stuff. And the fear. The total fear. Like I was in some weird film where I could be locked up out of nowhere … I was shitting it that I might be locked up even though I didn't think I needed to be. (SU2)*

There was an ever-present undercurrent of implicit, unspoken threat, with all people saying that they thought they had to be careful about what they say and do so that they don't 'trigger the alarm' around decisions to detain where:

> *The talking feels like that buzz wire game where you have to wind the hoop around the wire and not set the buzzer off … And you do that even though you're shaking like a leaf … you're thinking about that so much you tie yourself up in knots. (SU3)*

It is apparent for examples such as this that service users also used powerful figurative language to articulate feelings of anxiety and tension. The sense of threat is palpable.

Research suggests that MHA assessments are experienced as inherently threatening and deeply unequal (Buckland, 2020) and for all interviewees in this study there was a prevailing sense of coercion (defined earlier as 'the action or practice of persuading someone to do something by force or threats' (Molodynski et al., 2016)). There were perceptions of 'hard coercion' (Lidz et al., 1998):

> *Whatever you do or say you know what they can do … you know the situation is massive and you're fighting for your life. It's there in the room that they have all the power to lock you up. (SU3)*

Soft coercion (Szmukler and Appelbaum, 2008), enacted through communication, and representing a *perceived* threat of punishment or force (Gilburt et al., 2010; Lloyd-Evans et al., 2010) was also present:

> *It's a bit like you do with kids … do you want to do the dishes, or do you want to tidy your room … and they're looking out for you to say the right thing … to play the game I suppose … there's no actual choice and you don't dare tell them what you'd really want. (SU3)*
>
> *You're forced into saying the right thing … saying what they want to hear. (SU1)*

This final point, where service users acknowledge the need to say what doctors want to hear, is a further reference to the conversational manoeuvres at play. Quirk et al's (2012) observations of doctors 'letting the patient have it the doctor's way' was a form of steering the service user to make a choice from options already devised by the doctor. These forms of 'persuasion' were not viewed by service users as forms of pressure or manipulation in this study. Here, however, service users describe feeling forced into agreeing. There are clearly undercurrents of persuasion and coercion.

A recognition of a primary risk agenda was also apparent in one interview:

> *They thought I was a danger to myself and to car drivers, so they have to do something with me. (SU1)*

This person in particular had a concern, expressed in many different ways, around professionals' perceptions of risk and dangerousness[33]. For them, the MHA assessment was a place where AMHPs have a perceived public protection role with the AMHPs needing to balance state paternalism.

Service users from the national research project spoke about the impact of power and coercion in different ways. There was evidence that AMHPs' consideration of this is variable, as were their efforts to redress the balance within the assessment scenario. AMHPs were not always seen to acknowledge the threat arising from the potential for loss of liberty which, as discussed below, can sit in contrast with their self-perception. They may not always be sensitised to the significance of conversational dynamics:

> *They [MHA assessments] basically are very … overpowering and … the sort of questions that they ask you … kind of put you on the defensive, I think. (LE7)*

Here, being 'put on the defensive' along with being 'forced' is an articulation the way that communicative actions result in subjective feelings of disempowerment.

All people interviewed here spoke in general terms of subjective coercion (interventions *feel* coercive) regardless of the outcome. This, then, becomes a noticeable feature within the relationship and leads to a perceived lack of control which is closely linked with perceptions of fatalism.

Choice, Agency and Fatalism as antithesis of Shared Decision-Making

In keeping with much of the literature, a fatalistic view around the inevitability of a coercive outcome (detention) was apparent. All people interviewed in this study seemed to view the assessment and its outcome as a form of Hobson's choice (i.e. it was not really a choice at all). However, one (SU2) did believe that they had contributed in some way to the outcome (albeit by successfully 'saying the right thing') which supports the literature suggesting that being given information and having a sense of involvement reduced any sense of coercion (see Akther et al., 2019; Katsakou et al., 2011). Generally, all believed that the assessors were there as part of an inevitable control agenda over which they had little choice:

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[33] This person made several references throughout to 'risk to self and others' – a lay term rather than one worded in statute in this way and one which arguably exacerbates this type of stigma.

> *I knew I had to go through the assessment, I knew they had to do it and I knew I didn't have any choice. (SU2)*

It has been suggested that those who have been in the system longer have acquired a 'learned expectation' that they should assume a passive role in decisions (Degner and Sloan, 1992; Rosen et al., 2001) and this appeared to be the case in this study where the most hopeful person had not been assessed previously. Consequently, many 'experienced' service users enter into an unspoken or covert contract with professionals, adopting the role of a 'good patient' which is characterised by passivity and compliance (Joseph-Williams et al., 2014). There was a reluctance to contradict the professional and, rather, to 'do as I'm told' or to 'not cause trouble' where:

> *I didn't want to do this but where else was I going to go? What else was I going to do? You can't fight the powers that be, and it won't end well if you were stupid enough to try. (SU3)*

Again, to be assertive is to potentially run the risk of being seen as recalcitrant and where, as compliance must appear to be absolute, or punishment may be swift (Jenkins et al., 2021).

When asked whether they felt as though they could be more involved, all people responded that a 'know your place' stance and due deference was required. In general terms, they coalesced around the idea that there is a stratification system and that as 'just a patient' (SU3) you are required to act into a 'patient' role and identity – not least to avoid punishment and further degradation. Two interviewees described a lack of expectation, optimism or sense of mastery over what was happening. Both had been assessed previously and had very similar fatalistic approaches:

> *I've had these before and I knew that they always do what they want, so not really, no [I had no expectations or input]. (SU1)*
>
> *Well, I'm a veteran*[34] *… It's not the best area to be wise about … but I'm a graduate from the university of getting sectioned and it's all in their hands. Nothing to do with me. (SU3)*

These two were resolute in their perception that the decision was out of their control and, in keeping with Blakley and colleagues' (2021) research, the outcome was a *fait accompli:*

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[34] In a similar observation to AMHPs, there were examples of metaphoric language in keeping with military and combative language. There was an overall rhetoric and tone of survival.

> *Once we get to this stage there is bugger all I can do. Nothing. I feel like they should just hurry up and get on with it. Open the van doors and put me in. (SU3)*
>
> *I know I'm not going home when they get there. If I left and went and did something, it's on them and they're not going to have that. (SU1)*

One person did however have a sense that no decision had been made and, potentially, that they had had some influence:

> *I knew what could have happened, but I think we managed a bit of a compromise. As long as I did what I was asked I realised that they'd trust me to sort stuff out. (SU2)*

For service users from the national research project, the threatening aspects of a MHA assessment incorporated aspects of both hard and soft coercion when people were speaking specifically about a sense of threat:

> *[Detention] was used as a threat against me, you know, so I had no choice, I had to go in. (LE4)*
>
> *If I'm a problem, they can section me. I always thought it was a threat… We don't have power. We are mental patients. (LE11)*
>
> *I remember at my first assessment being terrified … I think it was a complete sense of loss of control … something was happening to me, and it was very scary. (LE5)*

In some cases, the reality of the situation felt like ensnarement. In language again reminiscent of a military scenario, an impending sense of attack was felt:

> *I wasn't aware that the assessment was going to take place. I thought it was just my care coordinator coming to visit and then all of a sudden, they all kind of ambush me at the same time … And the next thing I know is I'm being sectioned. (LE6)*

Similarly, there was a sense of surrender:

> *They just waltzed in … I knew they were a MHA assessment team so I immediately knew the possibility of me being coerced into hospital. (LE13)*

These powerful descriptions underlining their sense of powerlessness and isolation raise questions again about AMHPs' roles in MHA assessment in terms of the ways in which they balance (or are observed to balance) empowerment, involvement and self-determination. It also sits in contrast with their rationale around their role to challenge or disrupt routines as a force for good.

Autonomy, Independence and Advocacy: 'Who am I for'?

Following the ever-present concern with power relations for both AMHPs and service users, the tensions surrounding AMHPs' autonomy, independence and their enactment of advocacy arose frequently. Again, these were discussed from different viewing points with varying interpretations as to whether they were applied, rhetorical or merely aspirational.

In contrast with the literature, AMHPs in this study appeared to be comfortable with (or at times relished) the idea of disagreeing with medical colleagues' recommendations for detention (and thereby taking an independent stance) where appropriate. None spoke of the potential for damage to inter-professional relationships arising from the challenge to doctors' decision-making. For AMHPs in this study, there was a range of thoughts and feelings about autonomy, influence and independence:

> *I was very influenced by the doctor I think, although I like to think that I might have challenged [them] if they'd thought differently … I think I do [have independence, autonomy and mastery] … I think you have to fight for that sometimes and I'm trying to get more confident about it … I guess I could have argued the other way with the doctor, but he wasn't proposing a detention and I agreed with him … I think some doctors are kind of easier to direct than others. (AMHP 2)*

Another AMHP had similarly described ways in which they would 'help doctors to understand what decision they should make' (AMHP 3) which was clearly intended to be a more covert or soft form of persuasion or cajoling (Quirk et al., 2000). This approach is consistent with the preoccupation with organisational and professional hierarchies outlined elsewhere in this study and is also reminiscent of Stein's (1967) 'doctor nurse game', where nurses' interactions were carefully managed so as not to disturb the hierarchy and open disagreement had to be avoided at all costs[35]. Communication in this regard is subtle – as outlined above it could also be confrontational and deliberately designed to disrupt the hierarchy.

The importance of AMHPs' autonomy and independence has underpinned many concerns, particularly within the statutory reforms, where concerns about non-social workers becoming AMHPs has been founded on perceptions that nurses, in particular, would act as doctors' 'handmaidens' (Stone et al., 2020 p.54). Arguably, this concern has exacerbated existing (and historical) sensitivities and broader existential concerns for identity and freedom within the

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[35] Stein et al (1990) subsequently revisited this, stating that one of the players (the nurse) has unilaterally decided to stop playing that game and instead is consciously and actively attempting to change both nursing and how nurses relate to other health professionals.

work. One AMHP framed their decision-making and the influence of colleagues, particularly doctors, in terms of ‘argument’ where:

> *It has been testing … I do wonder if I am a bit passive … I think I would say something if I needed to … I've had quite a few assessments where doctors have kind of implied to the service user that they were in charge of the process, and they made the decision about whether someone was detained … I’ve had consultants say ‘I would put you under section 3’ and I've felt that that's actually you know not very accurate. (AMHP 2)*

Tensions around co-ordinating or ‘leading’ the assessment itself were also noted:

> *The consultant is very experienced and quite a lot older than me and has been doing the job a long time and I think he brings a lot of experience, but I think that does also mean that he tends to want to lead and I think if I hadn't been happy with what he was doing it would have been quite hard to challenge and I would have needed to think about how to do that … (AMHP 2)*

This AMHP was articulating their awareness of the ways in which their coordinating of the assessment itself is linked with empowerment and involvement and ultimately, as discussed in Chapter Six of this study, the impact on ‘floor space’ and epistemic privileges.

There were sentiments expressed that were similar to those found elsewhere, consistent with Vicary’s (2021) finding that AMHPs can feel like they were ‘somebody else’s bitch’ (p.260):

> *I think sometimes doctors expect you to be their lackey, and they don’t get that that’s not who you are. I think we all have to stand up to this all the time … It’s always been a core part of the work. (AMHP 3)*

This frustration seemed borne of a perception that they were there to use their power to balance that of the medical profession in respect of a social risk rather than a mental health orientation (Anderson-Ford and Halsey, 1984), and that they need to assert their independence and deliberately distinguish themselves from other professionals (Gregor 2010; Morriss, 2015; Buckland, 2014).

AMHPs’ grappling with authority, autonomy and the variables influencing decision-making were expressed in different ways. One AMHP highlighted these competing variables making decision-making the hardest part of the role:

> *I think all the other stuff you can kind of … turn into a process, can't you … there's a tick list of what you need to do … what information you need to gather and then, after you've made a decision, you know what you need to do but the decision bit … that's*

> *the crux of it isn't it? … You can frame things in all sorts of different ways, you can have a legal perspective, or you can sort of try and think about something from an ethical perspective … and balancing people's rights. (AMHP 2)*

The idea of AMHPs' and ASWs' competing and overlapping identities has been noted elsewhere (Quirk, 2000). AMHPs in this study also acknowledged the complexities, multiple aspects and 'different heads':

> *Every assessment's different. Sometimes you're debating the law, sometimes your buttons get pushed around values and … we come from different places … I sometimes think you get into work not knowing which 'head' you're going to put on each day … social worker, law expert, standing up for the vulnerable … I mean, who are we for, really? (AMHP 3)*

Interestingly this AMHP takes this a step further by asking 'who are we *for'.* An existential question about their profession, it also raises an interesting reflection around their self-perception and how they are perceived by others. If AMHPs see themselves as advocates who 'stand up for the vulnerable' and who play a 'Lone Ranger' part, arriving out of nowhere to challenge injustice and bring order to chaos (Gregor, 2010), then the experiences and views of service users appears to challenge this.

AMHPs' (in)visibility: In the shadows or authority for change?

When asked directly, no service user interviewees in this study were aware that one of the professionals in the assessment (and in the case of SU1, the only professional) was an AMHP and none recalled having this explained to them. When asked which mental health professionals were there, only one (SU3) appeared to know about the role, and that was only in practical terms:

> *Two doctors and one [person] I've seen before who sorts the paperwork and tidies up afterwards with getting you there [to hospital]. (SU3)*

This is consistent with perceptions elsewhere that AMHP work is seen as practical and processual and, in fact, that the AMHP (and their predecessors) are the 'mere transporter' (HMSO, 1957; Bean, 1986; Hargreaves, 2000). This perception was also apparent from the national research project:

> *I don't feel that they have any power to influence … it's always felt like … I'll bring your bag in the car behind you and I'll see you at hospital. (LE7)*

> *They’re normally like ‘I'm sorry I can't control that or that's out of my hands’ … they’re just one of the people coming to make sure I'm legally detained. (LE6)*

In the present study, there were mixed views as to whether the AMHP had an approach that was distinct from other professionals. ‘They are all the same’ (SU1), ‘the [AMHP and doctor] both asked similar questions’ (SU2) and:

> *They talked and asked questions but the same ones … I think they tend to merge into one … I think they all come from the same place. (SU3)*

Similarly, the findings from the national research project indicated that service users do not seem to be aware of the AMHP role or its independence. The extent to which AMHPs coordinate the assessment and conversation was not apparent:

> *Most of the time the AMHP … just kind of stays quiet and [they] have the doctors … do most of the talking. (LE6)*

The AMHP’s role as final decision-maker, seeker of alternatives to admission and applicant is not clear to people:

> *[The doctor’s] decision is that I should be sectioned, and I think they then convince the [others] to go along with it as opposed to … other solutions like staying at home … it just feels like if the AMHP’s there then I’m going to hospital … the AMHP’s involvement has always been … just going through the motions really … just one of a team. (LE6)*
>
> *I thought they just got pulled in to support what the crisis team were saying. (LE13)*

The view of AMHPs’ overall presence and visibility was delivered clearly here:

> *I just remember [the AMHP] writing copious notes … they kind of fall into the shadows a lot. I think that they're like background people for me … seem to play second fiddle to the psychiatrist. (LE7)*

It has, however, been noticeable (perhaps as the exception to the rule) where the AMHP has undertaken some coordination and had a presence:

> *In one situation she was brilliant, the AMHP … led in the interview unlike all the other interviews where the doctors took the lead and it seemed to be up to them. (LE4)*

Whilst AMHPs’ power and independence are understood to be illusory in that they are dependent on the availability of resources, they arguably have power and influence *within* the context of the MHA assessment. Here, they can influence the outcome by harnessing and asserting their professional value base, founded on anti-oppressive and anti-discriminatory practice, and bringing with it the requirement to challenge where necessary (Morriss, 2015;

Gregor, 2010). AMHP practice could attend to a redistribution of social resources and power. Within the interview data from the national project, service users described ways in which AMHP work was related to political activity and advocacy:

> *Alternatives to hospitalisation … don't exist in a lot of places but [AMHPs] need the ability to campaign for alternatives and stand up and be counted for the fact that not everyone needs hospitalisation … You could be taken to a crisis house … understand the impact of medication and why people might refuse it … And you should have that dialogue to be persuaded that it might work for you rather than it being forced on you … I knew they were going to force medication on me [in hospital] and that I didn't have a choice 'cause that's the way the system works. So it's more of a human rights perspective that they need to take. The fact that there's a lot of injustice in the system and the way that it operates … I want AMHPs to pick that apart and see why that's the case. (LE13)*

> *It's about calling [poor practice] out and recognising it when you see something that's not OK and having the confidence to do that. (LE11)*

There were examples of AMHPs successfully acting as advocate:

> *One thing [the AMHP] did do that was good … the psychiatrist wanted to put me on Clozaril … He was trying to force his perspective on me … and [the AMHP] did say it sounds like you've got capacity to refuse Clozaril because I wasn't refusing medication full-stop which would have been a red line for them. Not that it should be. (LE13)*

However, there are times when AMHPs were perceived to have missed opportunities to assert their position and to advocate on behalf of service users:

> *These people I saw … [could have] represented authority for change. And there was no real rapport there where they could have been so good and made a difference. (LE12)*

> *AMHPs need to rise up to the mark and become more powerful with the doctors … A lot are not strong enough to override the doctors … there needs to be a bit of training for the AMHPs to go 'actually I'm the one in charge here … I have a say too. Don't overrule me' … most seem afraid of the doctors. (LE4)*

In this study both AMHPs 1 and 2 said they tended to let the doctor 'lead' (where one of them said they were taught that way through picking up habits). The third AMHP saw themselves as having a more active role as an 'overseer' and 'Master of Ceremonies' of the assessment, but did have some opinion on their role as assessment coordinator:

> *I always try and introduce and then say I'll sit back and let [the doctor] talk and kind of lead it. (AMHP 2)*
>
> *I don't think I lead … I don't know if doctors would let me, but I was never taught that way and I suppose you just pick up on the habits, good or bad. (AMHP 1)*

It is unclear what form this 'overseeing' takes, but for this AMHP, the analysis in Chapter Six was indicative of professional challenges.

In the national project, one service user acknowledged the weight of responsibility inherent in the AMHP role and independent decision-making:

> *You're in a position of responsibility, if you can't shoulder it then don't do it … when I was an army officer, we used to have the phrase 'the burden of command'. Command is a burden, but it's a privilege … and be able to process an unpopular decision. … you know, if you don't detain this person on your head be it, well, actually I don't find that this person needs to be detained. And … that's my judgement. That's my job and I will take responsibility for that. (LE3)*

Overall, AMHPs in this study generally appeared to both enjoy and wrestle with aspects of their autonomy and independence. Interestingly, one AMHP saw these aspects as simultaneously the hardest and yet the most enjoyable part of the role:

> *[Hardest part of role?] It's an unregulated workforce … a free for all … [What is rewarding about the role?] Independence. The final say is the AMHP's and once you've decided not to detain it's not challenged. True independence and people accept it. Mental health social workers need approvals and managers can tell you what to do. We [AMHPs] have flexibility. (AMHP 1)*

Another AMHP was unequivocal about the satisfaction arising from independence and autonomy:

> *AMHPing is the only profession that gives you autonomy - you can make your own independent decisions. I enjoy that … I can say no and ask them for a clear rationale for their decisions. [It gives me] extra confidence and I like that. (AMHP 3)*

These AMHPs appeared to incorporate aspects of the five dimensions of AMHP work that were presented in Chapter One of this study. These include core motivations to do the work including anti-oppressive practice and the requirement to maximise service users' self-determination and moral and ethical dimensions arising from the independence of the role and the need to balance state paternalism. These may, however, not mirror service users' experiences. A further dimension outlined earlier was the way in which AMHPs bring a social perspective to bear on their practice.

AMHPs’ social perspectives and the ‘social model’

AMHPs’ (and their predecessors’) roles rest on social perspectives to deliberately and explicitly counterbalance the influence or dominance of the medical profession, and this is a significant aspect of the work. There have, however, been suggestions that AMHPs’ understanding of a social perspective in practice is variable, although they appear more inclined to adopt a ‘social determinants’ explanation (including the influence of employment, welfare benefits and housing on the development of mental ‘illness’) than a social constructionist approach (Karban et al., 2021). This theme explores the ways in which both AMHPs and service users interpret and apply these various models to make sense of their experiences.

Within the present study, when AMHPs were asked if or how they ‘brought a social perspective to bear’ (HMSO, 2008) in their assessments, they oriented to reasoning around systemic challenges and the pragmatic, practical resourcing aspects of seeking alternatives to admission. Responses related more to tasks and resourcing than attitude, perspective or a broader theoretical positioning:

> *I didn't need to [apply a social perspective] because the doctor wasn't offering an admission so there wasn't the option … he was going back to [X area] and I didn't know details of the services that would be available to him over there … so I was very much thinking about risk at home. (AMHP 2)*
>
> *That’s one of the hardest parts, the social perspective. We can’t use that if there are no beds and crisis services are non-existent. (AMHP 3)*

Within the assessment, there was an apparent social causation argument:

> *I don't remember the doctor asking many questions about [the service user’s] work and his financial situation which seems to me to be really important … I think I thought the fact that he’d lose his job was clearly really important to him and that weighed quite heavily. (AMHP 2)*

Another AMHP reflected on underlying perspectives as well as perceived professional differences:

> *AMHPs have a social work core profession and look at the bigger picture. Nurses say social workers get too involved but we're looking at contributory factors, root causes,*

> *hope, normalising feeling like that because of life … Meds are not always helpful. (AMHP 1)*

One AMHP took a more critical approach, consistent with Buckland's (2014) research suggesting that AMHPs do problematise concepts of 'illness' and 'symptoms' verbally and within the context of the assessment:

> *To demedicalise distress is not to delegitimise distress. You can respect and care for people's suffering without labelling it as illness or pathology. (AMHP 3)*

AMHPs' accounts varied around a knowledge-base resting on social determinants of mental 'illness' and with an understanding of mental 'illness' as a social construction.

Generally, AMHPs' accounts were consistent with Hall's (2017) framework analysis suggesting that their concepts or frames of risk were explored in terms of social crisis, social problems, complex relationships, coping mechanisms and a 'normal' response to a social situation rather than a focus on the identification of a mental 'illness' and individual pathologies. Interestingly, Buckland's (2014) research indicated similar findings when interviewing AMHPs but found that normative discourses relating to 'illness' and 'treatment' in hospital were reproduced within AMHPs' later written accounts of their decision-making. This study did not incorporate AMHPs' written reports, but it would be interesting to further understand how (or if) they articulated these relatively theoretical concepts in their written accounts of the assessment or whether theory sat apart from their practice as something that was solely academic.

Generally, AMHPs' challenges arose from colleagues other than their AMHP ones. These could be from difficulties with multi-disciplinary working, intertwined with a lack of understanding of the AMHP role and purpose:

> *[Mental health] teams … might say 'we've got you a med rec, we just want you to go out and finish the job' and that's when I have disagreements … I've worked with teams where they say 'well, we've done the assessments and we think this person needs to go to hospital' and I've left the med recs lying in the safe – you go and sort it. In that case, I would be pushing for them to send someone and work with me to do the assessment and to explain their thinking. (AMHP 2)*

> *A and E staff had a lack of understanding [about the AMHP role]. It was us and them … they were saying 'call yourself mental health. You're not therapeutic' and they wanted us to restrain [the service user] using hands-on. We can't do that. (AMHP 1)*

> *I don't think people understand … I remind them that a MHA assessment is a last resort, and least restrictive, they are too quick to refer. (AMHP 1)*

Again, the difficulties are attached to a diffuse and hazy position where the role is an amalgam of professional, organisational and values-based work. The ethnographic phase of this study highlighted ways in which AMHPs themselves appeared to find self-definition difficult. That it is low profile, poorly understood and in the middle of cultural differences between organisations has been documented elsewhere (BASW, 2016; ADASS, 2018; CQC, 2018; Stevens et al., 2018; Hemmington et al., 2021) including the role being misunderstood by the people who experience services and their families (Gregor, 2010).

Making sense of the lived experience of assessment

People with lived experience similarly applied theories, models and perspectives to make sense of their experiences in different ways. In this study, none subscribed to a purely medical, clinical perspective. All three oriented to explanations of stress and the ways in which vulnerability to this led to the current crisis point:

> *Stress. Too much work, too much beer … it makes you realise there's a fine line between normal and going over the edge. (SU2)*
>
> *I was in a bad way. I got my children taken off me, I felt like I had no life and wanted to end it. They have to put me in hospital for my own safety … but there's no treatment for it. (SU1)*

Perspectives that were different from that of mental health professionals was also noticed:

> *We're not all in the same place, really. Ever. I think they just think jabbing you will solve all your problems. My problems are never because I don't have enough chemicals in my system. (SU3)*

These areas were identified in Chapter Six as professionals' and service users' contrasting epistemic domains, and ones which were not openly discussed or reconciled in their assessments.

Within the national project, service users' perceptions rested on explanations around the social determinants of mental ill-health as well as observations of resourcing issues. At times, people were able to discern the AMHP's perspective and reflect on whether it was a social perspective. Doctors, on the other hand, were clearly associated with a medical position and a keenness to diagnose, to see people in terms of this diagnosis and to prescribe medication, whether or not the person fundamentally disagreed with this:

> *I was in deep conflict with a psychiatrist, and it used to deeply upset me. He saw things as being a physical condition and I didn't. (LE2)*

In contrast, AMHPs:

> *… seem to have a more social background and looking at us … for the person … the medical thing is what I'm against. 'Cause you've already got two doctors in there you need one with a different perspective. (LE4)*

One person positioned themselves within a social constructionist perspective and evaluated the MHA assessment scenario accordingly:

> *Social model perspectives are really important … even psychosis is socially constructed you know they're not biological entities and it's really important to get across [to mental health professionals]. (LE13)*

One person had experienced challenges in terms of a cultural interpretation of mental 'illness':

> *Some have a misperception about mental illness. I got the distinct impression that in some places they treat you like mental illness is some sort of crime. They perceive it differently in the Asian culture than the Western culture. (LE2)*

This aspect of feeling criminalised also subtly appeared when people with lived experience discussed power and coercion.

Models and techniques used in the lead up to a MHA assessment were critiqued:

> *I had a bad experience with the Crisis Team before the MHA assessment … they kept focusing on illness and reality-testing my beliefs and I didn't want to lose all of them. I was willing to give up some of them but not all of them and they wouldn't compromise 'cause they didn't see that I was competent to make that decision about how I should be treated – something I still disagree with to this day. (LE13)*

This lack of willingness to compromise also raises questions around whose responsibility it is for 'engagement' (a term often found within the rhetoric of mental health services) where this person is reasonably critiquing a cognitive behavioural perspective and requesting that this is modified around the fundamental qualify of their life and choices. Again, this also echoes Hall's (2017) findings that crisis team practitioners in particular are focused on the identification of a mental 'illness' and pathology.

Interestingly, different professional hierarchies were noted whereby medical members of the assessing team were perceived to have power and legitimacy:

> *I'd be thinking of the hierarchy – you're just a social worker. The doctor is higher level so how can you section me? I wouldn't have accepted it if an OT tried to section me. I'd have wanted the psychiatrist – I thought they were the head doctors. (LE10)*

This suggests that it is not only mental health professionals who have assimilated ideas of who is in charge.

Organisations and Resources

Several findings were subsumed within this theme as they were all inter-related. There were observations of AMHPs' practice styles as well as their coping styles which were influenced, or worsened, by inadequate resourcing (including time), all of which leads to moral injury. This was a theme where AMHPs and service users' perspectives were more closely aligned.

AMHP services have experienced restructures and changing work patterns, particularly with the development of full-time, round-the-clock AMHPs working alongside part-time or mixed-role AMHPs. Findings from the ethnographic phase of this study indicated some of the impacts of this, however, as yet there is no other available research relating to how, or if, these variations influence decision-making or practice more broadly. Interviews with AMHPs provided some thoughts:

> *We have full time and part-time AMHPs and to be honest I'm not sure how it makes a difference, but it does … how come we do one [assessment] and take our time but full-time AMHPs seem to knock out two or three in a shift? It doesn't add up … you can't just be a weather-vane or whatever it is and change with the wind depending on where you AMHP in the organisation … we all qualified the same [way]. (AMHP 3)*

> *The fact that I was asked to juggle two assessments really influenced what happened … you don't really have the luxury of time or a large pool of doctors to choose from … because I'd done another [assessment] I just carried on to interview this second [person] with just the one doctor who was with me… Potentially if he had needed hospital admission that wouldn't have been very person-centered 'cause he [would have had to] go through another assessment … I took the chance.* (AMHP 2)

Some negative references were made to AMHP colleagues within the service, echoing the in-fighting referred to in Chapter Five. AMHPs shifted positions regarding their colleagues being both a source of support and solidarity ('I can call on colleagues if I need them') (LE2) and as the subject of frustration:

> *There are lazy AMHPs who sit on work and avoid assessments. (AMHP 1)*

AMHPs' practice styles have not been attended to in detail in the literature. AMHPs who were interviewed in this study observed different styles of practice:

> *I think some [AMHPs] are … well, not rigid, but … are very much aware of the importance of explaining all the legal implications of what they're doing … and some aren't, and I think there's pros and cons to that because … sometimes it can come across as a bit brusque and not very warm … but, on the other hand, if you just have a cozy chat with someone and then suddenly go 'right now I'm going to detain you' … so yeah, I've seen people do it quite differently. (AMHP 2)*

As expected, the issue of resources was also apparent for AMHPs on a daily basis. This affected both their work and the 'service' that people get in different ways. Finding a hospital bed for those liable to be detained once again appeared to be the most problematic area of practice (CQC, 2016, BASW, 2016; CQC, 2016) even though this is not actually part of AMHPs' duties (DoH, 2015a para. 14.77). When asked directly to state the hardest part of the role, responses were in keeping with both this and the shortage of AMHPs in general:

> *It's straightforward … not rocket science … frustration around a lack of beds. And we need more AMHPs. There are always low numbers. (AMHP 1)*

Lack of resources were also linked with a negative impact upon the Empowerment and Involvement principle and choice:

> *I think the lack of resources really limits [Empowerment and Involvement] because there's lots of situations where I'd love to be able to say to somebody, well, there's a nice crisis house and if you went there we genuinely wouldn't be slapping a s5(2)[36] on you if you wanted to walk out the door or the crisis team can come and see you four times a day for the next week, when I know they can't, so yeah I think that's a barrier. (AMHP 2)*

> *To be honest if he'd said 'actually I feel really unsafe at the moment couldn't I just pop into hospital for a couple of days' that wouldn't have been on offer so … I'm struggling to think of a situation where there definitely … was genuinely a choice available to the person that we were assessing that we were prepared to offer them. (AMHP 3)*

Service users shared AMHPs' pessimism about the availability of options other than to detain:

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[36] Section 5(2) of the MHA is a doctor's holding power for people who are in hospital on an informal basis

> *Well, there is nothing apart from hospital, is there? My partner had already asked for help weeks ago and the crisis team said they are too busy with everything. (SU3)*
>
> *I probably just needed someone to listen to me. Someone to take me seriously. That hadn't happened so I suppose I just ended up there. You get nothing normally, so this is what happens. (SU1)*

This resignation to 'the system' being set up in this way was a reoccurring theme. Yet when all service user interviewees made reference to potential alternatives to hospital they talked in terms of stress and life events rather than 'treatment' that could only be provided in a hospital setting. This also included a critique about the adequacy, as well as the nature, of crisis services.

Service users from the national research project shared frustrations with existing models of services and practice. Here, around half of the interviewees expressed dissatisfaction with the lack of alternatives to hospital admission, including services that might provide a different way of working:

> *I would like a discussion as to whether or not I need medication … my aim will be to go into a Soteria house and to work through my psychosis there and come out the other side, not medicated … but obviously that's not available at the moment so that makes it really hard. (LE7)*

It appears to be the case that a lack of preferred types of intervention exacerbate service users' ambivalence about the outcome of the assessment and, again, there were mixed emotions about whether the 'right decision' had been made.

Time as a resource

One observation that arose several times, and one consistent with the literature outlined earlier, is AMHPs' lack of time and heavy workload such that they were observed 'rushing' through the work:

> *… not having the time … because they are pushed and rushed and 'later but today I have loads of people to see'… so the time's more important. (LE7)*
>
> *To be fair to AMHPs, they're rushed off their feet and there's a shortage of them. (LE4)*

This is consistent with evidence elsewhere that service users pity busy clinicians and try to shorten conversations when this appears to be the case (Hajizadeh, 2014). This may even be the case where service users' rights to information (DoH, 2015a) have been ignored:

> *The AMHP forgot to mention the outcome of it when he left, he was that rushed … He failed to tell me what was happening. I had to ask the police officers what was going on … Too busy to take the time, and that's what it felt like. (LE1)*

There were also views on AMHPs' practice and, significantly, the ways in which it influenced the potential for a relational approach (discussed further below):

> *I think they [AMHPs] will really struggle with [having more of a relationship with the people they are assessing] … I fail to see how it can be done … with the amount of workload they've got. (LE1)*

Limited available time is therefore also a barrier to effective shared decision-making approaches (Stevenson et al., 2000) where professionals are too busy and hurried (NICE, 2021). Service users' sympathy has been extended elsewhere, for example where they don't want to bother professionals or feel guilty about taking up their time (Bouma, 2014).

AMHPs in this study recognised too that they are not able to spend time with people when they are at their most distressed.

> *I do think that all that 'time to talk' stuff is a bit of a joke. There isn't time to talk when you need it most. We're always having to go on to the next thing. (AMHP 3)*

Whilst not expressed (or acknowledged) here, this difficulty in giving time is indicative of AMHPs high levels of burnout, stress and moral injury.

Emotions, stress and health

This theme encompasses the findings around AMHPs' emotions, stress and physical and mental health as well as their perceived ability to continue to practice. Two of the AMHP interviewees in this study were relatively newly qualified and they saw this as an explanation as to how they were 'still going'. The third recognised that the role is:

> *… time limited … don't they say we're ticking time bombs? I feel like one anyway … we're all ageing and knackered, that's what they say. They'd be right. You can't keep this up forever … I'm looking at the light at the end of the tunnel now [retirement]. (AMHP 3)*

Two AMHPs in this study made reference to feeling most afraid or at risk when alone in the dark or in an unfamiliar place:

> *I think I've only been a couple of times where I haven't felt very safe and they've both been when I've had to go to [area] after dark because I don't know [area] … I think it*

> *was something about it being dark and being somewhere that I didn't know very well that made me feel a bit uncomfortable. (AMHP 2)*

> *[I have felt afraid or at risk] … Executing a warrant, driving from one place to another in the dark shadowy night. Doctors had buggered off – you're feeling alone in an unknown area. I was approached as a drug dealer! (AMHP 1)*

This perceived 'abandonment', where they can be literally left on their own at the scene, has been noted elsewhere (Vicary et al., 2019). It is noteworthy that 'safety' was often interpreted in terms of physical safety, and not necessarily psychological safety as referenced by the national AMHP Workforce Plan outlined earlier (DHSC, 2019).

Psychological uncertainty has also been associated with AMHPs' anxiety and this was described here:

> *I am always quite nervous [when I start my shift] … I'm always worried in case I'll be in a situation where I don't really feel like I know what I'm doing and usually I feel better as soon as I've actually got the referral because I know what's involved. (AMHP 2)*

AMHPs in this study were, however, most likely to attribute the stress attached to the role as being derived from the lack of resources. This might be frustration around time delays and additional work (for example from trying to find a hospital bed) but it was more likely to be a consequence of their considering hospital as representing safety and asylum (in the true sense of the word) but being denied access to this – an area highlighted in Chapter Two of this study as leading to moral injury. All AMHPs made some direct or indirect reference to guilt and anxiety arising from having to 'walk away' from people in distress. As indicated earlier, applying for detention in the absence of alternative resources has been described as a personal failure, illustrated in the following:

> *I'm supposed to go out and solve the problems but you're never going to feel good about this. It used to be 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. (AMHP 3)*

AMHPs also described their inability to pursue a less restrictive option than detention, a statement in keeping with feeling forced to detain people in order to find a hospital bed:

> *Sometimes I've been involved with someone being offered an informal admission and on the face of it that seems like a brilliant idea but then they're told they've got to wait a week for it … how am I supposed to work with that? Hobson's choice, really, if they can get a bed if I detain them. (AMHP 2)*

Being cast into a ‘bad guy’ role can be stressful (Hurley and Linsley, 2006) as is the morally dubious and anomalous nature of the ‘policeman/executioner’ role (Quirk et al., 2000 p.38). One AMHP picked up on this:

> *I think other people know about people being sectioned (in quotation marks) and that’s one of your social work stereotypes, isn’t it, so I think people actually find that easier to get their heads around … I tend to be a bit flippant about it … or a bit macho … At work it’s almost like a sort of joke that I go out and do these terrible things to people. (AMHP 2)*

This theme of ‘doing terrible things to people’ arose elsewhere, where AMHPs referred to the emotional labour and dirty work aspects of the role in relatively disturbing terms:

> *You can’t keep forcing screaming little old ladies into the back of caged police vans and looking at the whites of someone’s eyes and seeing everything from abject sorrow though to mortal terror and not have to find some way of bleaching these events of the horrors of what you do to people in your mind. How could you sleep? (AMHP 3)*

Powerful descriptions such as this are visceral and yet were delivered in matter-of-fact terms. AMHPs don’t necessarily engage with their own trauma arising from the work they do. Elsewhere, this same AMHP viewed their role in similarly graphic and dramatic 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[37] shit … who am I to do that? (AMHP 3)*

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 is poorly acknowledged in the literature and in practice. This extraordinarily deep reflection, expressed in almost macabre terms, has an inescapable impact on practice and, fundamentally, ability to continue to practice in the role. This does not appear to go unnoticed with service users.

In the national research project, three interviewees with lived experience of assessment and detention made reference to the potential for, or actual burnout in the AMHP role:

> *A lot of the older, experienced [AMHPs] … all seem tired by the system and [there is] a lot of burnout in the role … it's a very stressful role. But you have to get on with it and have a stiff upper lip and all that … it’s just part of the job (LE1)*

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[37] This was applied in a context of religious or Shamanic cultural beliefs where the Psychopomp guides newly deceased souls to the afterlife.

There was also an apparent acknowledgement of AMHPs' moral injury arising from the inability to meet people's needs:

> *I think AMHPs struggle with the role because they don't have much alternatives to hospital admission … to be fair how are they ever gonna get this correct? If the AMHPs aren't supported? (LE10)*

Interestingly, one person made reference to 'the system' and offered to assuage AMHPs' potential guilt or anxiety:

> *If you feel [as an AMHP] you failed by detaining someone that is wrong in the sense that the system is geared toward giving help to those who most or they consider most need it … How would you feel [as an AMHP] if your client went and took their own life 'cause they were struggling? if you're going to change [this] … it's got to be done system wide … you've got to give them the power to get the help they need. You've got to give them resources they need … I wouldn't be here if I hadn't been detained. (LE1)*

The emotional impact on service users was also recognised, with descriptions of the impact of assessment and detention on their self and again the experiences of mortification (Goffman, 1968) attached to this.

Service users' stress: Mortification of the Self

The disempowering and dehumanising effects of detentions are ubiquitous in the literature and interviewees in this study made reference to feelings of 'shame', 'mortification, 'embarrassment' and stigma. Within the national research project, the assessment was experienced as being immensely threatening, with people describing anger, dread, trauma, loss of control:

> *People talk about life changing injuries in … traumatic accidents, but it can actually be a life changing situation to take a patient's independence away from them. (LE3)*
>
> *The Section 136 suite was a dreadful place… it was just a [filthy] mattress on the floor … and it took 23 hours to get this assessment. Horrendous … I've had flashbacks about that … there's a couple of nights I've woken up …. screaming in the middle of the night because of … memories of it … it was trauma. (LE4)*

Fear could be visceral:

> *When I looked out of the window and saw a big group of people, my stomach just sank … [I had] butterflies … I was shitting myself really. (LE10)*

In a particularly powerful phrase, the AMHP was portrayed as the very personification of death:

> *I took a very dim view of the AMHP … I used to think … I just don't trust this bloke … I used to regard him as the Grim Reaper. (LE3)*

This sits powerfully alongside the AMHP's perception of themself as a 'Psychopomp', as AMHP 3 said, above, where both invoke images and representations of immediate death. This invites an exploration of the acknowledgement and support AMHPs receive for their role whilst acknowledging that there is no formal debrief for service users despite a recognition (outlined below) that they are often unsatisfactory places to be.

AMHPs: Support and Leadership

Role stress exists, but in terms of workload and support more broadly, all AMHPs derived support from peers and AMHP colleagues and generally found formal supervision to be less useful. One AMHP did not think that AMHP Leads or managers had been particularly supportive:

> *AMHP Leads who go out to shadow – they understand issues on the ground … they get it … Some managers can lose touch with reality and what's happening out there. It's OK for you [managers who aren't going out to practice], you know Jack Shit about what's going on. (AMHP 1)*
>
> *I tend to do my own thing … I have supervision but it's more business-like than any wellbeing or 'how are you' stuff. (AMHP 3)*

This perception of peer support being the most effective is in keeping with the literature and is one area in which AMHPs appear to be united. All three AMHPs interviewed in this study found support from their peers – a finding in keeping with the ethnographic part of this study.

AMHPs have recourse to supervision and debrief – if not formally, then at least from their peers. Service users, on the other hand, may go on to experience further distress from a hospital admission. In the national research project, almost all people with lived experience of detention coalesced around the idea that hospitals are unpleasant and unhelpful environments. One or two recommended that AMHPs should consider this further as part of their decision-making:

> *Hospitals are not nice places to be … When you're doped up and you want peace and quiet … the worst thing you can do is stick me on a ward with people who are in crisis ... Hospitals just want to medicate you … AMHPs don't see you once they've shipped you off into hospital and you're drugged up to the eyeballs. They don't come back. (LE8)*

> *[AMHPs need to understand] what it actually feels like to be an inpatient … You can go on inpatient units today and still see the way that bullying happens. And you know the stuff around the power … how we take people's power away from them. (LE11)*

People in this study believed AMHPs to be largely unaware of the difficulties in hospital wards, perceiving that this is not part of the decision-making[38]. Yet, as discussed above, AMHPs do in fact experience conflict (and moral injury) arising from the lack of true asylum in the form of the hospital (Morriss, 2015; Abbott, 2021) and, further, they become 'numbed out' to cope with the 'half-truths' they are telling people about recovery in a hospital setting (Hemmington et al., 2021, p.65). As above, however, the issue is the relative lack of sources of support available to AMHPs and service users to reconcile these experiences.

People with Lived Experience: Ambivalence and Choice

Service user interviewees in this study, as well as the national study, expressed ideas in keeping with the limited literature outlined in Chapter One of this study, whereby retrospective interviews highlighted an acceptance that they had needed help that they had not recognised at the time. All had a sense of things getting out of control and this needing to be resolved but, understandably, none would have chosen the outcome to have been a MHA assessment or detention. All spoke of feeling embarrassed about it but said that things had improved and that their crisis and distress had resolved somewhat. The two service users in this study who were detained indicated that they thought the assessors did the 'right thing':

> *I didn't at the time, but I suppose [the AMHP] didn't have much choice if he thought I'd go and harm myself and he was probably right … It gave me a break and time to think. (SU1)*

> *It gave my partner a break … I trust her … It would be different if she wasn't involved but she gets me and has my interests at heart … so I guess they did too? … And I have to admit now it did improve things. (SU3)*

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[38] The Code of Practice to the MHA (DoHa, 2015) in fact asserts that 'the potential benefits of treatment which should be weighed against any adverse effects that being detained might have on the patient's wellbeing' (para 14.9).

In the national research study, around half of the interviewees indicated that, retrospectively, the detention was the right outcome:

> *I was in such a bad place … psychotic and delusional … that's when I got an assessment and was sectioned … that was the best place for me in my situation. (LE10)*

> *There's been times when the approach [has been] bad and horrendous but the outcomes of being sectioned is still probably the right decision. (LE6)*

There was also a belief that the detention was 'life-saving':

> *[Being sectioned] saved my life basically because I'm not in my right mind when I'm doing these sort of things … To be honest, looking back. It was the right decision, even though I've hated being in hospital. (LE9)*

The existing literature relates to the hospital admission (or the need for it) whereas, in this study, there was some ambivalence relating to the assessment itself. Paradoxically, given the potential for loss of liberty at the end of it, a MHA assessment may be an episode of a person's mental health care in which being heard, being involved and having an understanding of what is going on, are all important. One person reflected on this:

> *I've had a mixture of emotions or feelings about it … I guess I would regard it as both intrusive and positive … it made me talk about things and I was able to talk about them – I had to, didn't I? (LE3)*

Similarly, the opportunity to talk to mental health professionals was appreciated:

> *A discussion … They listened to me … That was the best thing that ever happened to me (LE8)*

This invites a conversation as to whether the MHA assessment could ever constitute a different form of crisis intervention where AMHP work is embedded within broader contexts of relational work.

AMHP work as relational work

MHA assessments should ideally be about exploring all options for service users, and not be a narrowly legalistic encounter or one where outcomes are stymied by a lack of resources. Deliberately understanding and enacting the relational nature of AMHP work sharpens the focus on services users' self-determination, maintains the AMHP's position of independence from clinical perspectives and reinforces the notion that the assessment (even if only from a service user's perspective) has more than a legalistic domain. It might serve to better frame AMHPs' uncertainty about their allyship, 'shapeshifting' (AMHP 3) and introspection in terms of 'who am I *for*?'. Refocusing a relational approach potentially de-emphasises independence from service users and it supports AMHPs to consider the ways in which they address the need for advocacy. Given the importance of the relationship, and the findings of this study in relation to the importance of communication, it is suggested that the entire encounter must be examined, and not just the point when a decision is made (Eliacin et al., 2014).

To do this takes time, and a more deliberate focus on the assessment:

> *Having enough one-to-one time [with the AMHP] is really important … It should be made into a much more prolonged process really … So I wasn't reaching out to them which I think you have to if you're going to get into a good dialogue with them about what the right decision is. You have to see their perspective. I didn't get that. (LE13)*

Sharing perspectives could and should be a more explicit focus in the work and training.

Democratised practice

This overall theme of democratising practice has aspects of Communication, Shared Decision-Making and Empowerment and Involvement subsumed within it. All overlap and underpin AMHP work as relational and communication-focused work. 'Communication' is broadly about techniques and methods, and SDM and Empowerment and Involvement are not distinct in the eyes of AMHPs and people with lived experience of being assessed and detained. Consequently, they have been brought together in this section to be discussed under the general theme of democratised practice.

Communication

All AMHP interviewees in this study recognised, albeit indirectly, the consequences of their interactional styles and the presence of empathy. AMHPs in this study spoke about communication by reference to observing others and, by implication, how *not* to do it:

> *I generally find when working with consultants that they are very directive and they kind of tell people that they've got problems … and this is what they 'should' and 'must' do and I'm not convinced that that's actually the best way. (AMHP 2)*

> *The doctor butted in a lot … some are reasonably balanced and will listen, but others need reigning in a lot. (AMHP 3)*

This latter quote again illustrates an AMHPs' intervention as part of coordinating the assessment. Where communication was seen to go well, it rested on aspects of listening and caring:

> *I was actually pleasantly surprised by how supportive and caring the doctor was [in this assessment] and he spent quite a lot of time talking and listening, so I did feel that was a good thorough psychiatric assessment. (AMHP 2)*

It was also seen as being indirectly linked to the AMHP's attitude:

> *[You need to] come across as calm. Persuasive. (AMHP 1)*

'Persuasive' in this sense may however be synonymous with 'cajoling' or soft coercion, described earlier.

Caution may be required, particularly during the bureaucratic, formal opening of a MHA, as a dominating and commanding style of opening invites confusion, discomfort and potentially fear when attempts are made at SDM and involvement at a later stage encounter (Frosch et al., 2012).

Service users in this study were asked about the professionals' attitudes and communication skills and style during the assessment. Their responses suggested a sense of being interrogated rather than being involved in a two-way conversation:

> *[The AMHP] just kept asking me questions … he didn't really listen to me. (SU1)*
>
> *They fired question at me – they need certain bits of evidence and all that, don't they? (SU3)*

SU1 and SU3, in particular, indicated that their experience of the style of questioning was that of neutral 'survey' questions which, as discussed earlier, conveyed indifference and represented a bureaucratic or 'anonymous' relationship (Thompson and McCabe, 2016).

There were some critical messages around AMHPs' attitudes, styles and skills: perceptions of the AMHP's capacity for empathy and person-centredness, conveyed through their methods and style of assessments:

> *I'm normally very psychotic and very, very paranoid, but I know the questions always tend to be very tick box-y …. Then if I feel like if you say a few key words or key phrases, that's what determines the outcome. (LE6)*

> *One thing I didn't like is that the AMHPs sat there scribbling all the time rather than looking at you … They sort of asked me things as though I'm taking part. But I'm not. They weren't looking at me. (LE8)*

> *Gauge the mood of the patient and know as much as you can. Let the patient relax and tell his/her or their story ... Respect and tune in to their stories … And I think it's important not to ask questions from a list of prescribed questions … that detracts from the human level. (LE3)*

Evidence of more helpful assessment techniques was offered:

> *Eye contact is very important … There are ways of asking questions. It's about tone of voice as well … It's about demanding an answer or inviting an answer... It's about the conversation you're having with the service user rather than you telling them what could happen … it's what I call 'a joint venture'… And I've got to give a good part of me for it to work. It comes down to collaboration, conversation … Not be us and them. (LE8)*

> *There should be a deep communication with a patient. It's not like fixing a broken car – there should be two-way communication. (LE2)*

Shared Decision-Making and Empowerment and Involvement

When AMHPs were asked about SDM, or techniques for 'doing' Empowerment and Involvement, there was a general perception of a lack of training and a limited understanding as to what these meant in practice:

> *I think that's what we're there for, although it's hard to know how to do that stuff [SDM]. Nobody ever teaches us how to do it. (AMHP 3)*

> *We've always had these principles … Empowerment and Involvement, Participation*[39] *whatever … but nobody really says what it means … it's never part of any training or anything … (AMHP 1)*

AMHPs were asked whether, in their MHA assessments, a service user wants to participate in the decision-making or not. There were some pithy responses:

> *Ask them. (AMHP 1).*

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[39] The 'Participation Principle' was the previous iteration of Empowerment and Involvement.

This raises questions around who does the work of engagement. For example, a counter to this perspective is found in a more considered response:

> *I think usually, if you can find a way to communicate with people, they usually want to engage in it or they don't say anything and that's when it's tricky 'cause you're not sure that they've fully appreciated what you're trying to do. (AMHP 3)*

There was an acknowledgement of obstacles, barriers and a consideration as to whether the conversation is generally accessible:

> *You've got to do all the obvious stuff like getting rid of language barriers and talking to people in a way that makes the whole process accessible … because if they don't know what you're doing you can't tell if they want to be involved in it. (AMHP 2)*

Other responses were more detailed and acknowledged the consequences of a lack of mutuality:

> *I don't really like situations … where you're almost saying … well if you won't talk to me then I'm just gonna have to go on what I think might be happening. (AMHP 2)*

In keeping with Goossensen et al's (2007) finding, AMHPs intuitively 'feel' if a service user wants to be involved. This area needs further investigation, not least as professionals' understanding of a situation cannot substitute actors' understanding of a situation (Garfinkel, 1967) and the risks of a variety of biases and assumptions are clear. Yet there were references to the 'intuitive' aspects as to whether a person wants to be involved or not:

> *I guess it's fairly obvious from things people say in people's body language … and that's often about how they're feeling. (AMHP 2)*
>
> *You'd be able to tell from their attitude … Within sixty seconds you can tell if someone is [too] unwell, very quick, and you have enough evidence [to make a decision]. (AMHP 1)*

AMHPs were asked how they understand what service users' priorities are:

> *Sometimes people will say … clearly like this guy said … his priorities were maintaining his relationship with his partner and not losing work … I don't think I went into the assessment thinking about his job so much … I'd always try it … ask what people wanted to happen and it usually comes out of that. (AMHP 2)*

In keeping with doubts outlined elsewhere as to whether SDM ever happens in mental health services for cultural, historical and epistemic reasons (Sandman and Munthe, 2010), two people with lived experience in this study perceived that they had no influence over the decision-making and they were unclear as to what influenced or informed the final decision. Their responses indicate that this took place toward the paternalistic end of the spectrum:

> *Don't know. Maybe to keep me safe? I don't know what they do. They just make all the decisions. (SU1)*
>
> *I don't know how they make the decisions – they don't tell you or share the formula. I don't know how they decide – it's a mystery – maybe they go to see the Wizard of Oz behind the curtain. (SU3)*

In some respects, this too is consistent with Goffman's (1968) observations of institutions, where the passage of information is restricted, and discussions take place away from inpatients (Goodman, 2017). The decision-making – and the power – were taken away from the person.

One person did experience congruence and empathy, perceiving that their specific needs and preferences had been taken into account:

> *They asked the right questions and listened to the answers. I knew that these two got it because they were on a level with me. (SU2)*

The interviewees were asked how they could have further participated in the decision-making:

> *I just kept saying that my life felt shit, but I didn't want to go to hospital. That's all I said, really. I didn't get to say much else. (SU1)*

This person is also orienting to a social model in their explanation of the problem, with a suggestion that this was not heard and that the only option was hospital. Further, there was an indication, as below, that people need to say what the professionals need to hear:

> *Stay calm and talk and give them the information they need so that [it gives the professionals] … is it reassurance? Is that the right word? (SU2)*

Again, there is resonance with the communication game referred to earlier – and one with high stakes. Here, this person is reflecting on their own involvement, apparently outside a formal and explicit shared approach. They too are aiming to be 'persuasive'. Conversely, not everyone may want to invest themselves in the assessment:

> *[The AMHP] just kept asking me questions to tick his boxes so I couldn't be arsed. I just wanted to be left alone. I told him what he needed to know. (SU1)*

In the national research project, none of the interviewees believed that they had been involved in the decision-making and all perceived a lack of influence, choice or individuality:

> *[I have never been involved in any decision-making] Just psychiatrists talking about medication … It feels like everybody is just put in the same box and treated the same way and given the same treatment but [they are] not listening to people's stories and backgrounds including things like trauma. (LE11)*

People's perception was that the decision had, in fact, already been made before the start of the assessment and that, again, their experience was that it was a *fait accompli* - the presence of the AMHP (and their colleagues) was an indication that they had foreclosed any option of negotiation:

> *It feels very much like they're looking for a reason to section you … other than looking to support looking at what's best. (LE6)*
>
> *I thought 'why bother … you're gonna do it anyway'. Right from square one … they were just going to sign their paper. There was no discussion. (LE8)*

People's perceptions of AMHPs' capacity for empathy were noted:

> *[The assessment] wasn't very long [and] it wasn't hitting the nail on the head [and not] helping me explain myself … [they needed to] … help me express as best I can. (LE10)*
>
> *The second time was better – let's have a chat and a cup of coffee a chat and listening. The [AMHP] was more in tune with things. They were willing to sit and listen … [Did that influence the outcome?] Oh yeah definitely… the questions weren't just one sentence and yes/no … things like that. (LE8)*

People who have had more than one experience of a MHA assessment observed AMHPs having different styles and approaches:

> *Some AMHPs have actually spoken to me like a human being … some … look at me as if I'm not there. (LE1)*
>
> *There is a great difference between the most hostile and the most caring. And then some don't care at all … Be professional, be friendly. (LE12)*

Overall, service users identify the service user-provider relationship as the bedrock of SDM (Eliacin et al., 2015). The relationship is not simply a prerequisite for SDM, it is arguably an essential prerequisite, framing the context in which SDM occurs and without this foundation, SDM might not be possible (Eliacin et al., 2015). Yet the notion of partnership as an essential element of SDM has frequently been under-emphasised in the literature (Montori et al., 2017). SDM and Empowerment and Involvement as merely rhetorical entities can lead to scepticism around the concept:

> *Empowered? Oh! They have to say this stuff, don't they? I think it's all just a bit of gloss, really. They still do it in the same way they've always done it and I've never really felt involved. I've never been invited in a realistic way … I think we're on different planets to be honest. (SU3)*

One AMHP even saw the rhetoric of involvement and SDM as a distraction from the morality of the work and, possibly, that the nature of AMHP work undermines the entire concept:

> *I think we pay a lot of lip service to it, really … I can always fill in the bit in the report that says how I empowered and involved people and … it's really important to listen to people … and you can show people respect and tell people what you're doing … but I think the suggestion that people have much of a say in what happens is not accurate and I think it's a way of kind of avoiding the … acknowledging the … bigness of what you're doing and the fact that it maybe isn't actually morally justifiable. (AMHP 2)*

From this perspective, more needs to done in terms of reconciling relationships and the fundamental nature of statutory mental health work.

Feeling judged in language and reality

Service users in this study experienced the assessment as infantilising, with descriptions of a paternalistic approach linked to the use of language:

> *You just need to bite your tongue, or you'll get grounded and locked in your room. Do as you're told. Be a 'good boy' and a 'patient patient' and all that … (SU3)*

References to an expectation of a passive and compliant role in decision-making (see Degner and Sloan, 1992; Rosen et al., 2001) were relatively frequent as were the expectations of being socialised to a 'patient' role, as above. One person echoed Timms' (2017) critique of terms that are usually attributed to behaviour 'of which we disapprove' (p.246). One comment was delivered in a defeated tone and with apparent, uncritical acceptance:

> *I got told by the doctor my behaviour was 'inappropriate' and I need to stop. (SU1)*

This returns the conversation to the extent to which AMHPs consider aspects of empowerment, and arguably dignity, within their role. It also again raises the question 'who am I for'? Interestingly, one AMHP linked their implementation of empowerment and involvement, in the form of advocacy, to actions taken 'behind the scenes':

> *I would argue that we empower and involve people, in a way, behind the scenes … not always centre-stage, in the assessment maybe but we're always thinking 'whose side are you on?' … it's not just an administrative role and you owe people your morality and, if you can't advocate for them, then don't do it. (AMHP 3)*

Here there is another metaphor to explain difficult scenarios – that of the stage. Similarly, Quirk (2000) observed that one of ASWs' various identities is that of 'impresario' and 'stage manager' (p.32) within their work and it is reminiscent of Goffman's (1956) concept of 'dramaturgy' or the metaphor of theatre for everyday life.

Empowerment: Centre-stage, Backstage or a 'Kitchen Conversation'?

Themes of secrecy and taking empowerment, involvement and decision-making backstage were evident in this study. 'Waiting for the verdict' (Blakley et al., 2021) is a habitual characteristic of the assessment, a point at which there is an invisible line in the conversation whereby both AMHP and doctor believe that they have gathered enough information to make a decision, nod to confirm the tacit agreement that they have heard enough and then retire elsewhere to make their decision. Two service users in this study both noted that the assessing team left to make the decision elsewhere. In the national research project, this was experienced in similar ways:

> *In the situations I've been involved in … they have all turned up and asked questions then they all disappear off into another room or into my garden … and that's one of the worst bits. (LE6)*
>
> *I lived in a block of flats and the people who questioned me … went on the stairs and had a chat to make a decision. (LE10)*
>
> *I think I went outside. I went outside the front door while they made their decision or into the bedroom or something … they obviously said they needed to talk and review it … was kind of … Insisted that I go. (LE7)*

One person was open-minded about the fact that retiring to have the conversation elsewhere might have been a source of support or advocacy:

> *I don't know if [the AMHP] did things behind the scenes to support me. (LE13)*

At times, for a variety of reasons such as sensitivity or perceptions of risk, it might be the right thing to do to have this discussion elsewhere. It may also, however, be that AMHPs act instinctively, habitually, from a paternalistic perspective rather than considering the potential benefits of sharing the interactional agenda with all parties. Arguably, an attitude shift might mean that AMHPs could consider the ways in which their agenda setting is associated with institutionalised positions of power and deontic authority (Stevanovic and Peräkylä, 2012) and where this might create conflict with aspects of empowerment and involvement in practice. It is also a place for reflection on the relative professional roles and identities and AMHPs' often keen sense of independence and advocacy. Where AMHPs think they have done a 'good job', there is an acknowledgement of advocacy.

AMHPs: Job fulfilment

The many variables in this chapter reinforce the idea that AMHP work is beyond legalistic. AMHP work has been described as a form of advanced practice (Hemmington et al., 2021), associated with higher status arising from the complexity and ambiguity of the work (Morriss, 2015) and prestigious due to the need for advanced skills (Gregor, 2010).

There was an acknowledgement of AMHP work as being prestigious and autonomous:

> *The beauty of AMHP work - not being born yesterday, not junior … It's a powerful role but I have not let it go to my head. (AMHP 1)*

AMHPs also appreciated the variety inherent in the role:

> *No two days are the same. We meet people from different backgrounds. The variety of the work and meeting people at crisis point. (AMHP 1)*

Referred to earlier in terms of the emotional aspects of the role, AMHPs describe the 'buzz' or adrenaline attached to the work. Here, it is described as an 'adventure':

> *I've said I hate all the uncertainty, how I got really anxious, but I guess I also get a little bit of a kick out of that … It sounds terrible but it feels like a little bit of an adventure … and a bit of life that you wouldn't have seen otherwise … it feels quite privileged really and if you're not careful, it can verge on voyeurism but it's a bit … like traveling … You're going to a new place and meeting new people and a new situation that you've not come across before. (AMHP 3)*

More frequently, however, the capacity for AMHP work to be relational and, to an extent, therapeutic was considered:

> *If I feel like I've had plenty of time spent time with the person, that helps … if I've had a good long discussion with them … when you feel like you've made any kind of connection and … they've felt listened to … some people give you an*

> *acknowledgement of that, even when they're quite angry about what you've done. (AMHP 2)*
>
> *I think if you've done your job and managed to keep someone out of hospital then you can go home a little bit happier. (AMHP 3)*

In a potentially paradoxical turn, given the AMHP's role as applicant, one AMHP perceived that AMHP work was more of a therapeutic piece of work than their (social work) day-to-day job which entailed 'doing to':

> *Sometimes in your day-to-day job it feels like you're on the outside 'doing to' [the person] and this can be like that as well, but sometimes it feels like more than that … it does feel like you're involved in it at quite a key crisis point. (AMHP 2)*

This same AMHP identified the 'emotional connections' attached to the work:

> *You're going to be intimately involved in that for a while … well, that's quite powerful and it also feels … it can feel like quite an emotional connection … I've had people hug me after I've detained them which is really weird … it can feel as if you've done something quite helpful as well. (AMHP 2)*

Ambivalence exists for AMHPs as it does for service users.

Chapter Conclusion

Themes identified from the AMHP interviews highlight aspects of power, relationships, democratised work and the potential for advocacy. Different identities indicated that there is a Janus-faced nature to AMHP work – but this was something that they were all, generally, comfortable with.

Reconciling AMHPs' and service users' perspectives within this analysis is interesting, not least with the tensions around empowerment and involvement and where (or how, or if) this takes place and whether AMHPs are 'centre-stage' or 'in the shadows'.

Overall, themes are often consistent with those arising from previous chapters. Some of these resonances are particularly powerful, not least the sense of fatalism, MHA assessment representing an ambush or the depth of emotion attached to the experiences. More can be learned and gained from understanding the nuances of communication.

Framing a MHA assessment as an opportunity or as something 'positive' or intentionally relational is unusual. A very small number of service users and only one AMHP saw it as therapeutic or an opportunity to talk. This chimes with AMHPs' reflections or aspirations captured by one AMHP in Abbott's (2021) study:

> *We should be trying to interact in a therapeutic and meaningful way, and you always have this dream that it could be a transformative experience, but mostly they're not, they're emotionally pretty administrative and quite distressing for clients (p.1371).*

One rationale for this study is that there is a fundamental need to sharpen the focus on this area of practice and to open it up for scrutiny. The research here is consistent with suggestions elsewhere that people are often unaware of the nature of the assessment, describing the experience as 'deliberately secretive … and Kafkaesque' (Blakley et al., 2021). A significant underlying theme is that of advocacy which appears to be implicit and an attitude underpinning empowerment and involvement and Shared Decision-Making. The following, final chapter draws together the findings from this and the preceding chapters and it considers the nature of the relationship between service user and AMHP and the possibilities for communication in MHA assessments.

Chapter Eight: Discussion, Implications and Conclusion

Introduction to chapter

AMHP services are changing around an AMHP function that has ostensibly stayed the same. The ethnography and interview phases of this research considered the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make. MHA assessments have a private nature and are undertaken by professionals away from public gaze and without public scrutiny (Bean, 1980; Sheppard 1993) and to date, little has been known about how AMHPs communicate with and relate to service users and how they apply and enact the Empowerment and Involvement principle and Shared Decision-Making as part of their overall decision-making around detention. In this study, observations and fine-grained analyses explored the ways in which AMHPs facilitated empowerment and involvement and promoted SDM in the process of MHA assessments. AMHPs' perspectives and experiences were explored, and these were considered as part of overall dynamics and power relations that came to the fore within MHA assessments.

This final chapter revisits and reconciles core themes and findings within the study, considering their implications for practice, law and policy development and training. It reviews the findings of the study along with a recognition that there are significant social and political forces that shape aspects of AMHP work and, arguably, the assessment itself. Themes are summarised and drawn together as a whole.

Changing landscapes and new horizons? Through a lens of service (re)structures

The AMHP service in which I undertook the ethnographic phase of the study had been undergoing transition and reorganisation in keeping with the national picture of an increasingly wide variation in the way that AMHP services are operating (ADASS, 2018; DHSC, 2019; Skills for Care, 2021). In this study, full-time AMHPs' roles had been newly developed to work alongside mixed-role AMHPs. More broadly, this restructuring had taken place within a national context of reducing resources for service users and a shortage in AMHP numbers. Indeed, the move toward increased full-time AMHP services was arguably a similar measure to rationalise resources. At times this study painted an emerging picture of power struggles and fissures that had not been anticipated as part of the restructures. The new organisational landscape was revealing insights, not hitherto apparent in the literature, and there were new existential questions, fundamental to AMHPs' identities, as to what constitutes a 'proper

AMHP'. The findings suggest that there are significant professional and organisational contextual factors influencing AMHPs' practice.

In the midst of these practice changes AMHPs were struggling with intricacies of power. The more familiar perceptions of hierarchies and handmaidens had been apparent but in less familiar ways. Some AMHPs in this study were perturbed by matters of control over their work. For example, they perceived a compromising of their fundamental independence in terms of who was in charge of whom, for example around the allocation of work.

Hierarchies in AMHP services

This study found emerging challenges to AMHPs' ostensible statutory autonomy through their perceived lack of organisational autonomy. This new organisational landscape was one in which some AMHPs perceived themselves to be part of a stratified system. Their relative full-time and part-time positions had been cast in terms of promotion and demotion.

AMHPs and their professional representatives have long been alert to the idea of hierarchies creating compromises, albeit that these concerns related originally to ASWs' inherent independence within a context of medically dominated mental health services (BASW, 1977). Indeed, this was a rationale for consolidating statutory independence within the 1983 Mental Health Act. Similarly, the idea of doctors' 'handmaidens' has existed below the surface (and occasionally been made explicit in the literature) in terms of AMHPs' perceived imperative to challenge medical colleagues. The legacy from the Victorian asylums, where the physician expected his (sic) attendants to observe his rules (Connolly, 1856 p.37), has been evaluated in terms of the legacy of the 'handmaiden role' for the nursing profession (Cohen 1981, p. 140)[40] yet AMHPs in this study appeared to be vigilant to any expectations of a similarly subordinate attendant (or 'lackey') role and throughout this study appropriate resistance, or 'standing up to this', was a core part of the work. The findings from this study suggest that the concern for hierarchies had sown seeds within the AMHP service through new rules and instructions about the allocation of assessments. In contrast with research to date, AMHPs' own colleagues were not automatically perceived to be their allies and peers.

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[40] For clarity and to assert my own position, it has been noted that social workers do not necessarily have a monopoly on progressive values and that AMHPs from other professional backgrounds are no less committed to anti-discriminatory and anti-oppressive practice or no more willing to be swayed by authoritative medical professionals. Nurse AMHPs are familiar with this trope and indicate that, in comparison to social work AMHPs, they can 'talk the anti-discriminatory talk with the best of them' (Hemmington et al., 2021 p.35). Further, in this same study a doctor described a nurse as a 'turncoat', suggesting that they had somehow betrayed professional expectations by becoming an AMHP (op.cit., p.36).

Cultures and practices: Old values, new problems?

AMHPs’ decision-making takes place in the absence of guidelines and written rules and there is no established theory or evidence base for practice. As such, decision-making is informed by aspects of the AMHP’s self, their knowledge base and, potentially, other variables. In this study there was no one clear culture or mode of practice and, rather, they appear to diverge and be reproduced locally, sustaining tacit practices (White, 2006). At times, my study recalls Lipsky’s (1980) concept of the ‘street level bureaucrat’, where AMHPs’ work was influenced by the need to balance the tension between political and policy imperatives, the agenda of local management and the professional and peer cultures within which practitioners operate (Wells, 1997).

Lipsky’s (1980) theory developed out of his interest in the intersection of politics and policy and approaches to policy implementation comprising both top-down policy theorists (policy as a blueprint implemented by organisational bureaucracy) and bottom-up theorists (policy as created in a complex field of tensions and demands by resourceful frontline workers) (Evans, 2016). Within this study, the AMHP who suggested that ‘I know it’s not legal … but the law is interpreted differently’ (p.184) represents the ways in which the complex nature of the work leads AMHPs to use Machiavellian approaches in that they adopt methods that would generally be regarded as bad, in order to pursue ends that are good (Denzin, 2010). This is arguably also a form of resistance to their sense of lack of control over their work. AMHPs appeared to be saying that the professional value-base, advocacy and concern for service users’ distress took precedence which in turn resists the pressures that would result in moral injury. Generally, the five dimensions of AMHP work introduced in Chapter One captured an understanding of the differing practice imperatives that AMHPs in this study used as they reflected on what a ‘proper AMHP’ might be.

Chapter Five highlighted the ways in which AMHPs’ use of figurative language conveyed their difficult experiences including the ways in which they were ‘doing rebellion’ (Camp et al., 2020) within the service - not least as this was more apparent and profound in group settings. AMHPs’ language in this regard was revealing of extant social relations and this related in many ways to much wider political issues. It was here that I also realised the ethnographer as ‘political bricoleur’ (Denzin and Lincoln, 1999; Rogers 2012) where research findings have political and policy implications.

Overall, some AMHPs had perceived that the restructuring had culminated in a challenge to their autonomy and independence, touching on their existing existential concerns for identity and freedom. In addition, worse still, their own AMHP colleagues were compromising this autonomy. If the restructured teams are having an influence on practice in these new and unanticipated ways then future consideration needs to be given to whether, or how, this serves to have an impact on their decision-making[41].

A crisis of identity and purpose: 'Who are we *for*?'

Ongoing introspection and attempts to measure 'good practice' were further refined in the interview phase of the study. For one AMHP this was distilled to a thought-provoking question underpinning identities and aims: Who are we *for*? These struggles and tensions arose from the priorities that AMHPs ascribed to their work, for example whether it was, or remained, a values-driven venture or whether approbation and 'good practice' was attached to a need for speed.

I later learned, both from undertaking the national research project pertaining to AMHPs and service users' experiences that these concerns were apparent elsewhere and are, potentially, becoming a national problem. For example, in this national study one AMHP expressed regret that at times the work seemed to be 'an exercise in who can do it the quickest' as part of an overall 'macho', 'JFDI' environment[42] (Hemmington et al., 2021 p.60).

The Janus-faced aspect of AMHP work was apparent here and questions around 'whose side are we on?' illustrated this. There has long been an underlying assumption, or expectation, that the AMHP will be an advocate on behalf of the person or be 'the voice of the powerless in the context of an increasingly bureaucratized society' (Prior, 1992, p.108) and critics of the 'assessments done fast' appeared to be alert to the compromising of this advocacy role. Certainly, in this study many references were made to AMHPs' resistance and struggles for control, where this arose from a position that prioritised values-based work and the application of autonomy and independence as a tool for good. One of the aims of this study was to seek to understand the dynamics and power relations between AMHPs and service users and, overall, it was apparent that this area of interest was not limited to the assessment scenario.

AMHP Work as a 'Political Activity'? The political landscape

AMHP work was referred to on more than one occasion as a 'political activity'. At its simplest, this perception appeared to mean adopting a values-based, rights-based, justice-focused

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[41] As part of my 'Policy-Maker Self' I have highlighted these issues for their implications for both AMHP work and trainee AMHPs' placements around the potential for maintaining values-based practice and ongoing maintenance of the statutory competencies in a DHSC working group with which I am involved.

[42] Interestingly, given concerns highlighted above, this was a nurse AMHP.

approach within the processual aspects of the work (seeking alternatives to hospital or challenging discrimination or oppression). At times it meant challenging professional colleagues as a form of advocacy. It also reflected the micro politics within the service, outlined above. When explored, it meant different things to different people and AMHPs asking 'who am I for?' reflected a level of ambivalence in this sphere.

The politics of resources

AMHPs' inherent advocacy role underpins the principle of least restriction where the AMHP is called upon to ensure that detention is used only when alternative forms of care are not appropriate. It was only when the field research was completed and I continued to reflect on the implications of this for practice did I consider that the 'Efficiency and Equity' principle was, on paper, as prominent as the other guiding principles within the Act and yet it had largely been rendered meaningless. This principle states that:

> Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. (DoH, 2015a p.22)

All those involved with statutory mental health work are required to apply this principle as with the others, but no reference was made to this for the duration of the study. As Chapter One highlighted, the whole premise of the ASW and AMHP roles assumed that there was an alternative model of care and treatment for which they are a gatekeeper (Sheppard, 1990). In some respects, there was always a false premise attached to this aspect of the work and the hopes around principles of least restriction and finding alternatives to hospital, expressed within the campaigns of MIND and BASW during the 1970s, have not been realised. Service users have a similarly weak position and they bear the brunt of community services' failure to have been expanded at the same rate as hospital services have contracted (DHSS, 1986) or, in fact have shrunk or disappeared altogether (BMJ, 2022). As Prior (1992) highlights, AMHPs who are themselves powerless cannot easily empower others.

The politics of organisations

It was suggested in Chapter Five that work such as AMHP work has become a technical-rational endeavour when it is arguably a moral one, and there is a 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 in 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. Focusing more explicitly on the nature of AMHP work would attend to AMHPs' moral distress or moral injury, applied earlier in this thesis to the constraints making it impossible for AMHPs to do the 'right thing'. In this study there was an articulation by AMHPs of the type of 'social suffering' identified by Bourdieu et al. (1999) as being the gulf between the reality of their occupations and their more deeply held ontological and professional beliefs (Smith, 2011).

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 struggling with the misalignment of the organisational values and their individual values which will inevitably increase stress (Rajan-Rankin, 2014). AMHPs in this study 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. Moth (2022) similarly outlines the ways in which neoliberalism has 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. AMHPs in this study appeared to be arguing for a more explicit reorientation from a culture of managerialism to a culture of relationships in AMHP practice specifically (Dwyer, 2007) and across mental health care more generally (Moth, 2022).

AMHPs' moral injury (predicated upon their inability to do their main job of finding reasonable alternatives to hospital detention) has been increasingly apparent. To further compound this, where hospital beds *can* be found, they are perceived to be damaging and un-therapeutic. In this study, the AMHP who suggested that colleagues and others think that their service is 'Sections-R-Us' was expressing this with feelings of demoralisation that their work is seen to be based on a simple request for service users to be detained as a matter of administrative convenience (p.135). Ultimately, this creates the existential angst illustrated at times through the use of distressing, even macabre language about what AMHPs are 'doing to' people.

In many respects, AMHPs and service users appeared to be troubled by the same things: the lack of alternatives to hospital, alongside their experience that hospitals are unpleasant and unhelpful environments. Service users in this study believed AMHPs to be largely unaware of the difficulties in hospital wards and yet, as outlined earlier, AMHPs experience conflict arising from the lack of true asylum in the form of the hospital. In this study, some AMHPs spoke about their inability to meet peoples' needs in terms of personal failure and, again, a form of moral injury. They were leaving people struggling, walking away and had 'failed at every turn' (p.200 in this thesis).

Spandler (2016) observes that rates of detention are increasing whilst finding a hospital bed is becoming impossible in some areas. This is in addition to the suggestion that AMHPs feel forced to detain people. From this perspective, psychiatric abuse is posited as being over-emphasised at the expense of psychiatric use, and for Spandler a new and different form of psychiatric resistance is borne out of a recognition of the shift to ‘psychiatric neglect’.

Overall, AMHPs seem to lack a clear ideology to accommodate the broad political and relational aspects of their work. Interviews with AMHPs highlighted a lack of clarity around social perspectives being alternately, or simultaneously, based on the availability of resources and the conceptualisation of ‘illness’ or a social determinants position. Yet Sedgwick (1982) offers a view of mental illness that is not simply a social construction, nor is it that which is represented by a narrow biological or medical psychiatric approach. For Sedgwick, to reduce diagnosis and treatment to consideration of single body parts or systems is to neglect the influential psychosocial, economic and political factors. Again, Sedgwick called 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).

Spandler and Poursanidou (2019) similarly point to the unhelpful binary oppositions in critical debates about mental health settings (physical/mental; social/medical; psychiatry/anti-psychiatry and so on) and call for these to be more openly debated. Their inviting of an ambivalent position would appear to accommodate AMHPs’ ‘angst’ and their lack of clear framework within which to work. Spandler and Poursanidou (2019) recommend ‘unsettling’ or ‘troubling’ these binary oppositions more explicitly. This reflects AMHPs’ general perspectives where acute suffering is acknowledged as real, but it cannot simply be reduced to psychiatric intervention (Spandler and Anderson, 2015; Plumb, 2015). Neither, indeed, can it exclude people who believe that psychiatric support, medication, or intervention is needed or works for them (Beresford, 2016).

Spandler and Poursanidou (2019) therefore advocate an approach that is context dependent, where a person’s unique needs and situation are balanced (Callard, 2014). It follows from this that there needs to be a rebalancing of the traditional focus on diagnosis and treatment with prioritisation given to personal and self-determined perspectives and choice. The challenge, however, is to provide choice that is relevant (Piasecki and Hanna, 2011). Caton and Kilyon (forthcoming, 2023) discuss their striving to campaign for changes to the mental health system to incorporate healing, 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. Empowerment and Involvement, self-determination and Shared Decision-Making all imply an element of choice[43] – of which both AMHPs and service users currently have very little[44]. This study suggests that an explicit reframing of AMHP work as relational work which recognises psychiatric neglect and service users' rights to 'treatment' (howsoever defined) might support AMHPs to consider the meaning of advocacy or allyship. Powerful messages were delivered by one service user who spoke of AMHPs' needs to campaign for alternatives to hospital, to stand up and be counted and to 'pick apart injustice' (p.194). Again, AMHP work was connected with political activity and advocacy.

AMHP work as relational work

Detention (including its potential) can set an antagonistic context for relationships and create a 'them and us' atmosphere (Barnes et al., 2000). Service users in this study described ambush, a sense of *fait accompli* and having little discussion around options and alternatives to hospital admission, leaving them to believe that the only outcome could be admission (Barnes et al., 2000; Blakley et al., 2021). This is experienced as particularly problematic where mental health professionals literally take the decision-making and power elsewhere (the 'kitchen conversation') and the person is left worrying and 'waiting for the verdict' (Blakley et al., 2021; Hemmington et al., 2021).

The debate about what made a 'good AMHP' appeared to rest on a separation of styles and practice in terms of whether AMHP work is apparently functional, legalistic, and measured by speed or whether it is more allied to relationship-based, person-centred work. Elsewhere, AMHP work has been described as a socio-relational process involving a focus on the person in their environment and in relation to others, such as family and professionals (Abbott, 2021). The present study highlighted the ways in which it is also fundamentally about communicative approaches and a fine-grained level of advocacy. Arguably, understanding the relational nature of AMHP work as a conceptual resource sharpens the focus on services users' self-determination, and it also maintains the AMHP's position of independence from clinical perspectives.

Service users highlight the ways in which difficult experiences can be mitigated by good interpersonal relationships, good communication and by being respected, listened to, believed and understood. This study mirrored the available research, reviewed in Chapter One, in this

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[43] During the course of this study, the reforms of the MHA were published, and the Empowerment and Involvement principle is set to be replaced with 'Autonomy and Choice', discussed further below.

[44] The contexts and aims of this study are to consider the ways in which practice attitudes, approaches and methods can be developed. It is worth adding, however, that at the time of writing, the National AMHP Leads Network are discussing ways in which their work can be more explicitly and publicly 'activist' which offers further scope for optimism and consolidation.

respect. Coercive interventions are typically experienced negatively, but their impact may be mitigated by mental health professionals who share information and power and conduct themselves with warmth. The outcome of detention may well stay the same, but enabling a person to feel respected as a human being is itself an important outcome.

AMHPs are required to maximise service users' self-determination and one way of viewing this is through a lens of relational autonomy (Entwistle et al., 2010). Here, we are not entirely free, self-governing agents and our decisions will always relate to interpersonal relationships and mutual dependencies (Mackenzie, 2008). Considering work as relational is to recognise participants' multiple, dynamic self-identities and diverse roles as well as the cultural norms, social structures and diverging practices that all affect the work (Entwistle et al., 2010). AMHPs use their communication skills as part of relationship-based practice and an understanding of the social processes within a MHA assessment. The aim is to support service users' autonomy by focusing on identities, epistemic domains and a recognition of the impact of power, stigma and the diminishing and the demeaning consequences of statutory assessments. Relational thinking, along with professional imperatives, requires AMHPs to support service users in a way that is autonomy-supportive (Roe and Davidson, 2006). As was illustrated in Chapter Six the difference between communication that is either supportive or undermining of autonomy can be subtle and, evidently, cannot be judged without understanding the significance of communication from all perspectives.

Analysis of data in Chapter Six illustrated the ways in which AMHPs' relational activities made visible the ways of embedding empowerment and involvement in practice. AMHPs undertook advocacy in subtle ways, and they coordinated the assessments and their various agendas in ways that actively shared the floor with service users. AMHPs' coordination role can therefore be based on a recognition of the inequality of the relative weight given to participants' interactional contributions, and their vigilance can enable them to better steer the development of decision-making interaction on the micro-level as well as acting as applicant at the meta-level. A focus on relational dynamics and being explicit about what happens behind the scenes would open this area of practice to greater scrutiny.

Chapter Seven evaluated the ways in which AMHPs were more explicitly focused on their professional relationships with doctors (and the power and relative independence therein) than they were on their relationships with service users in terms of the presence of power. This raised questions as to whether they had the same obligations to maintain the relationship between themselves and professional colleagues as they do with service users. An important consideration around 'who we are for' is whether SDM and empowerment and involvement rest on an approach that actively de-emphasises independence *from service users* (Mol, 2008) or, rather, which supports AMHPs to consider the ways in which they address the need for advocacy or even allyship.

Whilst AMHPs' power and independence are understood to be illusory in that they are dependent on the availability of resources, they arguably have power and influence *within* the context of the MHA assessment. Here, they can influence the outcome by harnessing and asserting their professional value base, founded on anti-oppressive and anti-discriminatory practice, and bringing with it the requirement to challenge where necessary (Morriss, 2015; Gregor, 2010). In a micro sense, AMHP practice can explicitly and deliberately attend to a redistribution of social resources and power. Chapter Six highlighted the ways in which AMHPs made efforts to mediate this as consideration was given to turn-taking and participants' positioning in MHA assessments, including who goes first. Control over this agenda was associated with the institutionalised positions of power and deontic authority (Stevanovic and Peräkylä, 2012).

Service users appear to identify the service user-professional relationship as the bedrock of SDM (Eliacin et al., 2015). The relationship is therefore an essential prerequisite, framing the context in which SDM occurs, and without this foundation SDM might not be possible (Eliacin et al., 2015). Yet the notion of partnership as an essential element of SDM has frequently been under-emphasised in the literature (Montori et al., 2017). Indeed, one AMHP in this study expressed scepticism around the concepts (p. 203) highlighting the ways in which SDM and Empowerment and Involvement are seen as merely rhetorical entities that are out of the grasp of AMHPs in a relational context. This paradox highlighted the need to build on the work that AMHPs were observed to do and to develop awareness or view this as a training need.

Mental health service users arguably exhibit autonomous decision-making by not acknowledging (or agreeing with) a problem or 'illness' model and therefore declining the input of mental health professionals (Amador et al., 1991). The SDM model is based on negotiation and encouraging participation with the goal of educated decision-making, but negotiations may be to merely consider accepting negotiation in the first place (Kasper et al., 2010). Perhaps a starting point is to address the basic level of threat inherent in each encounter. Without effective communication, shortcomings in communication will quickly lead to empowerment failure and an early undermining of a service user's autonomy (Ubel et al., 2017). Only an attitude shift will support a sharper focus on the fairer distribution of participants' epistemic and deontic rights within MHA assessments, and the findings from this study suggest that this shift needs to be in the direction of a relational, or democratised, approach.

An attitude of democratised practice

The overall theme of democratised practice has aspects of Empowerment and Involvement, communication and SDM subsumed within it. All overlap and underpin AMHP work as relational and communication-focused work. As approaches, SDM and Empowerment and Involvement are not distinct in the eyes of AMHPs and people with lived experience of being assessed and detained. Consequently, they have been brought together in this section to be discussed under the general theme of democratised practice. ‘Communication’ is broadly about techniques and methods, and this study indicates clear training needs attached to these.

Empowerment and Involvement: Principles and attitudes

This study suggests that AMHPs’ specific and measurable communicative actions need to now be explicitly acknowledged as one method of *doing* empowerment and involvement. This is important not only in terms of developing good practice, but also in terms of statutory reforms where SDM is increasingly being referred to and which AMHPs will need to evidence in their reports. It is also argued here that empowerment and involvement is part of statute (Principle) but that it is also a practice attitude or position (principle) and part of an explicit and deliberate attitudinal framework.

Chapter Six illustrated that the adoption of a fine-grained study of communicative actions in MHA assessments highlights the ways in which AMHPs, at times, would seek to repair and return epistemic privilege to service users. Through the calibration of epistemic domains, AMHPs were focusing on communicative actions and contingent understandings. Specific types of questions served to advance or block conversations and these appeared to be subjectively and objectively important in hearing and inviting service users’ ideas and preferences. There was evidence that AMHPs coordinated movements within the assessment itself and had techniques that returned the floor and restored privileges to service users. At times AMHPs aligned themselves with service users and shared perspectives. They shifted their identities, alignments and epistemic communities as part of nuanced conversation. Communication moved beyond a static, linear exchange of information the more the service user was empowered to be involved within it. In this respect, the AMHP could be observed to return the ‘voice of the life world’ from the ‘voice of medicine’ (Mishler, 1984) to the service user. Their positioning could be liminal and fluid. This is important in terms of an understanding of AMHPs’ coordinating role. Yet these same AMHPs, when interviewed, were not aware of or did not acknowledge these conversational manoeuvres and priorities, suggesting that this took place at an intuitive level.

Coordination, choreography and the conversational dance

Usually applied to the organisational aspects of setting up an assessment, this study suggests that coordination extends into the assessment where AMHPs were observed to coordinate, choreograph and act as conductor. At times this had resonance with Björkdahl et al's (2010 p.513) observation of nursing staff in inpatient units adopting a 'ballet dancer' approach which:

> functioned as a means of initiating relationships with patients and was consistent with a caring approach. It involved sensitive and perceptive behaviour … with the intention of generating trust and signalling a desire to provide care. The use of imagination, patience and intuition was expressed as key non-verbal techniques wherein the nurses used themselves as a finely tuned instrument. (p.513)

The 'bulldozer approach', in contrast, was observed to be representative of nurses being the guardians of the safety and structure, sometimes by using force and coercion (both verbally and physically) as part of a controlling paternalistic attitude and an objectifying view of patients (p.514). AMHPs' use of repair displayed the ways in which their conversational manoeuvres maintained interaction (or mutual involvement), the distribution of power and were also often intertwined with hearable displays of empathy.

Interestingly, whilst this often seemed intuitive, AMHPs did acknowledge the times they deliberately 'helped doctors to understand what decision they should make' (p.190) which was clearly intended to be a more covert or soft form of persuasion or cajoling (Quirk et al., 2000). Communication in this regard is subtle and it was designed and used to both maintain and disrupt the hierarchy. Yet it was apparent from interviews with service users that they too are part of this conversational dance in the ways in which they deliberately say what they think professionals want to hear to give them 'reassurance' (p.215). There are clear aspects of power imbalance here where, again, to be assertive is to potentially run the risk of being seen as recalcitrant and where compliance must appear to be absolute, or punishment may be swift (Jenkin et al., 2021). A close observation in the subtle moves relate to Quirk and colleagues' (2021) observation of doctors' 'letting the patient have it the doctor's way' or, indeed, whether service users are equally creative with their approaches. Overall, Chapter Six illustrated the ways in which interactants' moves and steps are in tune or out of step but are rendered explicit and observable through Conversation Analysis.

Shared Decision-Making

In addition to the Empowerment and Involvement principle and the AMHP's requirement to maximise service users' self-determination, MHA assessments take place amidst policy rhetoric and organisational aspirations for the principles of coproduction, ‘working in partnership’ and the embedding of SDM techniques (NICE, 2014 p.10; NICE, 2021a). Yet in mental health settings, SDM is seen to lag behind the broader medical field in embracing a vision of partnership (Adams et al., 2006; Drake et al., 2010; Matthias et al., 2013; Morant et al., 2015). This may, in part, be due to the varying approaches to and understanding of SDM.

Shared Decision-Making in practice

The literature highlights varying approaches towards, and definitions of, SDM and the field is conceptually scattered (Bae, 2017; Makoul and Clayman, 2006; Moumjid et al., 2007). It also implies that SDM relies on objective criteria and rational behaviour with rhetoric such as ‘patient involvement’, ‘autonomy’ and ‘joint decision’ (Vogel et al., 2021). Yet this focus arguably ignores the interpersonal systems and information exchanges between parties and, as such, it upholds asymmetry (and paternalism), not least as professionals have an information monopoly. A model that does not focus on active communication merely sees the service user as a passive recipient who is ascribed one of two possible states – understanding or not – which gives little space for considering participation (Kasper et al., 2010) as well as empowerment and involvement in the moment.

Many models of SDM see knowledge and information as being transmitted from sender to recipient by linear transfer, with an assumption that this information remains unchanged during transfer and that it is represented on the recipient’s side in the same form. It is based on the idea of a digital information model where interferences and biases do not occur. However, people make decisions by constructing an internal, mental representation of the decision context or problem and it is this representation that is evaluated to reach a decision, and not the original information (Moreau et al., 2012). Crucially, this study suggests that representation is also informed by competing models of mental distress and that epistemic differences are inherent. This includes the clear epistemic issues at stake in upholding, or rejecting, prevailing orthodoxies for making sense of mental distress and then formulating treatment, care and support (including framing this by detention). Meaningful discussions can be compromised by practitioners’ assumptions about ‘insight’ – an assumption which can exaggerate inequalities between service users’ experiential knowledge and the scientific knowledge base of practitioners (Adams et al., 2006; Morant et al., 2015). This study suggests that representation is also informed by competing models of mental distress and that epistemic differences are inherent. Interviews in Chapter Seven suggested that AMHPs were somewhat in the middle of differing or competing theoretical and conceptual models.

Viewpoints and practice models

Within the SDM literature there appears to be no consensus as to how the ‘sharedness’ of the decision-making process relates to the culminating decision (Lewis et al., 2016). This study began to address what, exactly, is being shared in a MHA assessment.

SDM may be understood to refer only to the final decisional *endpoint* of an encounter which, if this is made without the service user (i.e. as part of a ‘kitchen conversation’), cannot be understood to be shared with the service user[45]. SDM has also been highlighted as potentially representing a *process* (here, the MHA assessment) which *leads up to a decision*. In this case, AMHPs coordination and use of techniques including repair and epistemic privileging are a tangible representation of this. This raises the question around who ultimately makes the decision.

Ultimately, SDM models have inconsistent underlying values. This study suggests that more attention needs to be paid to the intrinsic meaning of Empowerment and Involvement and whether it means communication *techniques* with methods supported from the findings from Chapter Six of this study. It may also mean a more fundamental *attitude* and conceptual shift into viewing AMHP work as active relational work. If SDM is difficult to define, it will also be difficult to enact.

There is a need for AMHPs to explicitly consider their position and objectives. For example, Adams and Drake (2006) offer practice imperatives that could be imagined as points on a continuum from service users’ passive stance to their active participation. The goal might simply be to increase every person’s participation, albeit with further understanding and training around techniques. At the other end of the spectrum would be the absolute upholding of service users’ autonomy and choice which, given the purpose and reality of the MHA assessment, would be impossible.

Both full ‘patient choice’ (or autonomy) and paternalism models have been characterised as competitors of SDM but Sandman and Munthe (2010) suggest that this need not be the case in practice. They use a sliding scale analogy, the endpoints of which are extreme versions of paternalism and full person choice respectively. Either end has a professional monologue (involving only one person) and neither extreme is of itself compatible with SDM, but the variations in between them may be.

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[45] This study did not focus on the content of this ‘kitchen conversation’ and so a further, and future, area of research ought to also consider who makes the final decision at this (exclusive?) end point – the doctor, with the support of the AMHP? The AMHP, with the support of the doctor?

Adams and Drake (2006) recognise that moderating and mediating variables also include relationship quality. This reflected the views of service users' interviews from Chapter Seven. The relationship should be a focus in and of itself, and one borne out by both findings from this study and the body of research indicating that this is of the greatest import to people being assessed and detained. Emanuel and Emanuel (1992, p.8) offer an interpersonal position, suggesting that caring in the very moment of interaction is missing in a strictly monological, paternalistic decisional approach. These positions are illustrated in the following stages:

1. Sharing as venting: the professional talks with the person and listens to their thoughts and concerns
2. Sharing as affirmation: the professional talks and listens *and then does their best to affirm and endorse the person's thoughts and concerns*
3. Sharing as caring: the professional talks and listens, does their best to affirm and endorse the person's thoughts and concerns and, *at the same time, tries to comfort and reassure them*

To bring this into a dynamic practice setting, and into the domain of the MHA assessment, Sandman and Munthe's (2010) position offers further stages which are layered on top here:

4. The professional deliberately hears how the person leads their life, explicitly understands what is important to them and *then deliberately and explicitly incorporates this information into the decisional process.* (p.74)

Consideration could at this stage also be given to whether consensus is (or should be) a necessary component of SDM, or merely considered to be a positive side-effect of sharing (Sandman and Munthe, 2010). Either way, this fourth point is a tangible effort to involve, and it is one which should become an explicit feature of the AMHP's mandatory report. It enables deliberate and systematic sharing through attempts to intervene in conversations and to be vigilant to the promotion of service users' epistemic domains and individual understanding.

Chapter Six of this thesis introduced ways in which professionals' interpersonal characteristics can act as barriers to SDM. These were generally consistent with the evidence elsewhere, in that they include situations where authoritarian or dismissive professionals, who dominate decision-making encounters, do not listen to or respect patients' concerns, or use negative verbal or non-verbal behaviour. Similarly, focusing merely on treating a 'disease' is problematic in mutual conversations (NICE, 2021) and there is evidence that an excessive use of a medicalised approach may serve to increase the likelihood of coercion (Verbeke et al., 2019). This again refines a focus on all parties' models of understanding.

Developing reciprocity in practice means considering the intervention as a form of active, values-based practice which always starts with the person's perspective whilst seeking a balance between legitimately different perspectives (Emanuel and Emanuel, 1992). At this stage, only after all deliberate and unambiguous attempts at negotiation have failed should there be paternalistic decision-making (Sandman and Munthe, 2010). In the final stage, the AMHP still acts paternalistically in that it is they who interprets the information, reasons from this to a decision and then makes the decision. However, the 'sharing' in this 'Patient Adapted Paternalism' brings information communicated by the service user into the decision-making process by *explicitly and vocally* treating it as an instrument for arriving at an optimal decision (Sandman and Munthe, 2010 emphasis added). Listening to the service user, supporting them to consider their preferences and discussing mutual priorities forms the basis of an 'interpretative model' (Emanuel and Emanuel, 1992).

Developing these can be the basis upon which to consider a clearer theory and evidence base for AMHPs' interventions and communicative actions. Crucially, it also means that empowerment and involvement techniques can be recorded more systematically than they are at present. It may also mean, for some, that reconciliation of different voices and perspectives may occur through a greater focus on communication in the assessment. Again, consensus will not be a necessary component of SDM in a MHA assessment, but a consequence of a deliberate communicative approach may mitigate perceptions of coercion. SDM becomes an attitude as well as a process.

Service users may choose to abrogate control and give responsibility for the decision to the professional (Elwyn et al., 2001; Elstad and Eide, 2009; Hickey and Kipping, 1998). Some mental health service users have viewed sharing as initially prioritising autonomy but, if that is not possible, deferred to professionals' judgement (Woltmann and Whitley, 2010). Other people may be less interested in making decisions about detention but be keen to choose where to go but again there is an emphasis on meaningful choice. The statutory principles of Empowerment and Involvement are arguably synonymous with the principles of SDM. From this perspective, there is a need for a more deliberate and deliberative approach that re-engineers how professionals and service users work together (Drake et al., 2010). The skills required for SDM are unlikely to be developed, let alone applied, unless the professional agrees with its underpinning ethical intentions.

Overall, if AMHPs accept that individual self-determination is a desirable goal, then their professional imperative is to support service users to achieve this goal wherever feasible. Key tenets of self-determination and relational autonomy (Makoul and Clayman, 2006) apply. At its core, SDM rests on accepting these are formed from the building of good relationships, respecting both individual competence and interdependence on others (Elwyn et al., 2012). Elsewhere, mental health professionals have acknowledged the need for an attitude shift:

> It's about having a relationship where patients don't feel talked down to, where it's not punitive and you're not behaving in a parental role but you're trying to work with them on an equal – as equal as you can – relationship … if you're really going to have genuine partnership and not tokenistic attempts you have to shift your whole orientation towards how you work with people and how you see yourself. (Mental health nurse in Chong, 2013)

There is evidence that professionals use a paternalistic style because they are acting, automatically, from their own or their institution's values and methods (NICE, 2021). Arguably, AMHPs in this study were resisting the assimilation of values (organisational) that undermined their need to spend as much time as is needed with people they were assessing.

It has been suggested that those who have been in the system longer have acquired a 'learned expectation' that they should assume a passive role in decisions (Degner and Sloan, 1992; Rosen et al., 2001). Similarly, and as indicated within the interviews with service users in this study (p.217), many enter into an unspoken or covert contract with professionals, adopting the role of a 'good patient' which is characterised by passivity and compliance. Interventions should then focus on providing people with explicit 'permission' to change these contracts and promote their self-efficacy, or confidence, in achieving this (Joseph-Williams et al., 2014). Chapter Six concluded that the extent to which shared decision-making is possible is dependent upon each person's epistemic rights (i.e. rights to knowledge) and their deontic rights (i.e. their rights to determine future action) (Stevanovic and Peräkylä, 2012).

Overall, it has been a clear position of this study, consistent with the methodology outlined in Chapter Three, that communication needs to be understood as a co-construction of reality via a greater concentration on *process* and the interactive nature of the communication (Siminoff and Step, 2005). Applying a Conversational Analytic approach to MHA assessments means that communicative actions, dynamics and power relations between AMHPs and service users are observed and revealed in real time. By focusing on the process of AMHPs actually doing their work (rather than retrospective accounts) it became apparent that the AMHPs' coordinating role could often (if not always, to a greater or lesser extent) extend into the assessment. It is contended here that this should be a more explicit aspect of AMHP practice. AMHPs' coordinating role appears to go well beyond the setting up of the assessment in processual terms. It is indicative of a form of relational work.

Developing a democratic and relational approach: The Open Dialogue example

This study has evaluated communication and ways of 'doing' empowerment and involvement and SDM within a context of democratisation. The discussion turns here to consider Open Dialogue (OD) approaches as an exemplar of a more fully democratised approach to care and treatment which, arguably, could be foundational for realising ideals of SDM[46]. These ideals were found, in this research, to be implicit and diffuse in terms of AMHPs' current practice. The need for communication to be understood as a co-construction of reality invites a greater concentration on communicative processes and the interactive nature of communication. The OD approach is reviewed here to illustrate alternatives to current conceptions and traditional modes of practice.

Seikkula and Olsen (2003) describe OD as 'a network-based, language approach to psychiatric care' (p.403). Drawing on Bakhtin's (1984) dialogical principles, there is an emphasis on the 'poetics of the interview room' and it considers the language and communication practices in face-to-face encounters (Hoffman, 2007). Rather than being seen as the cause of problems or objects of treatment, service users are 'competent or potentially competent partners in the recovery process' (Gleeson et al., 1999 p. 390) and the team develop a trustworthy context which specifically and deliberately legitimises each person by explicitly hearing and responding to their voice and to their point of view with them being supported to use their own language (Olsen et al., 2014). The process of interviewing, rather than the characteristics of the person or their family network, is emphasised and there is a concentration on the conversational method rather than on the intervention. This means treating everyone involved as a member of a partnership.

Pakman (2000) identifies the 'poetics' of language and communication practices in face-to-face encounters where a 'polyphonic conversation' means that there is room for each voice and, crucially, listening has greater importance than an interview formula. Attention is paid to responding and reflecting (hearing, understanding and acknowledging in an explicit way) and an open, participatory, transparent, jargon-free conversation is the aim (Rober, 2005). From this perspective, then, the approach is not a model that is applied but more a set of practices that are developed throughout the system. It is, fundamentally, an attitude and a shift in orientation. Decisions, including on treatment and hospitalisation, are discussed and made while everyone is present. There are no separate staff meetings for treatment planning (Seikkula and Olson, 2003 p.407). There are no kitchen conversations.

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[46] At the time of writing, Open Dialogue approaches and techniques are being developed in MHA assessments in a team in England led by a consultant psychiatrist and an AMHP.

The OD approach is framed by Bakhtin's (1984) idea of dialogue as the basis for communication including among professionals, the person and the social network. It is a theory of democratic communication. From a social constructionist perspective, psychosis is a temporary but terrifying alienation from shared, communicative practices: a 'no-man's land' where unbearable experience has no words and consequently the person has no voice and no genuine agency (Holma, 1999; Seikkula, 2002). The therapeutic aspiration is to create a common verbal language for the experiences that would otherwise remain embodied within the person's psychotic speech and private, inner voices and hallucinatory signs. The Bakhtinian approach to dialogue derives from a tradition that sees language and communication as constitutive of social reality. Constructing words and establishing symbolic communication is a voice-making, identity-making, agentic activity occurring jointly 'between people' (Gergen, 1999). The crisis becomes the opportunity to make and remake the fabric of stories, identities and relationships that construct the self and a social world (Seikkula and Olsen, 2003). OD incorporates Bakhtin's concept of dialogism into a co-evolving process of listening and understanding. Every utterance requires a reply and there is an aesthetic (a fitting together of utterance and reply) to the dialogue that makes it 'dialogical' rather than 'monological' (i.e. a speaker without a contributing listener) (Volshinov, 1996). As meaning only occurs in an ongoing exchange, the speaker and listener are intimately joined together in making sense of the psychotic episode.

Crucially, and to return to the 'before, during and after' of a MHA assessment, in an OD approach, whether the person is hospitalised or not, the same team remains involved and continues to meet with the person and the network until the situation is no longer urgent. This idea of 'psychological continuity' is critical to the approach (Seikkula and Olsen, 2003). For Pakman (2000) the 'micropolitics', here seen in a context of the larger institutional practices, are essential in supporting an OD approach. Traditionally, most forms of therapeutic interventions have been 'office models' that are part of larger systems, while OD is a communal practice based within social networks. To embed an OD approach, then, models of dialogue that can address the poetics of the interview room need to also address the larger bureaucratic politics that can constrain and deaden them (Seikkula and Olsen, 2003). Similarly, Pilgrim (1990) argues for a 'democratisation of mental health services to break down medical dominance and to make decisions about patients a matter of negotiation with them, not about them' (p. 224).

Open Dialogue's effectiveness is therefore part of its institutional and training contexts. It works well when it is part of a democratic ethic and a larger ethic of participation and humility within the organisational culture. Organisations with procedure-driven, managed-care environments will find OD much more difficult to develop (Coffey et al., 2001) and, yet, a further helpful payoff is that an overall ‘participation’ approach reduces the ‘calcification’ of mental health perspectives as staff take on different positions within the system (Seikkula and Olsen, 2003). Seen in this way, the OD approach is not a model that is applied but a set of practices that are established throughout the whole.

For Manchester (2022), an AMHP who is part of the aforementioned service embedding OD approaches in MHA assessments[47], what has been overlooked for too long is that the most important resource in AMHP work is the AMHP’s self as part of a deeply relational activity that means getting alongside people and their families quickly and sensitively during a period of significant distress and upheaval in the social system. As an AMHP, he believes that this:

> demands that we listen both to service users and to our ourselves – to our own conflicts, to our own internal voices, and to our biases and vulnerabilities. AMHPs can make a significant contribution to correcting epistemic injustice at the front door of the Mental Health Act. Approach a MHA interview with the curiosity of a ‘not-knowing’ stance.

Mental health professionals have authority by virtue of their institutional and legal status. Chapter Six highlighted the ways in which AMHPs, when facilitating a collaborative approach, worked to downgrade the authority connected with their position. At times, AMHPs subtly demonstrated preferences to provide agreement and maintain social solidarity with service users. They appeared to attempt to balance, or even relinquish, some of their power to involve people more authentically in their assessments. Consistent with this, as part of a systemic and polyphonic approach, OD is also disruptive of the individualised focus that characterises contemporary mental health services and in this sense the approach is both democratic and respectful of social networks, connecting with matters of inter-dependence as much as independence.

It has been documented in this study and elsewhere that a lack of dialogue with the person being assessed has been a source of frustration for AMHPs who regret not having the necessary time to spend with people and to effectively implement these ideals of democratised practice. A high workload will inevitably prevent meaningful engagement and leave insufficient time to spend with service users to focus on SDM. Within this context, SDM is not the path of least resistance and is less likely to be considered (NICE, 2021). This again highlights the need for broader systemic support approaches that places communication centre-stage and protects the time for meaningful dialogue.

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[47] This project has been aptly titled ‘Conversations Across the Divide’.

Reference was made, above, to professionals' need for humility as part of a democratic, shared approach. Recognising the power and information hierarchies, along with the potential for practice to reinforce existing oppression, invites commitment on the part of mental health professionals to apply epistemic humility. This means recognising the boundary of their own expert domain as well as the potential contribution of service users. For Ho (2017), epistemic humility is a disposition and a commitment to appraise both what we know and do not know and to understand our claims to knowledge accordingly. Again, this requires a refocusing of attitude and approach which is applied in practice through language as part of method.

AMHP work as bridging work

Chapter Six outlined the ways in which Conversation Analysis looks at the way that participants assert, contest and defend their claims to knowledge within their interactions. They adjust their actions and understandings in keeping with what they know about the world (Heritage, 2013). As part of AMHPs' relational work and the potential for deliberate methods to empower and reach across an epistemic divide, a metaphor of bridging may support practice.

Both Buchanan-Barker and Barker (2005) and Halldorsdottir (2008) used the concept of bridging to better connect with and support people in distress. Here, the development of a professional relationship is the building of a bridge which symbolises an open connection as well as a comfortable and respectful distance. Either professional or service user can initiate connection by using verbal and non-verbal communication and progress is reached by recognising each other as individuals rather than as service user and professional.

For Buchanan-Barker and Barker (2005) the 'need to build bridges' between alienated individuals means constructing a means of crossing threatening water to reach something of importance on the other side. Literally and physically, any bridge will have two sides and there will always be a gap. Metaphorically, this represents the separation brought about by differences of understanding, power or status. Further, on the communicative bridge:

> Traffic is not one-way, but it allows those using it to move back and forwards if they wish. When two people meet on a 'bridge' there is no fixed meeting place, in the same sense that the bridge is a 'seamless' connection between two opposites. In snooker and billiards, the 'bridge' – which may be an actual device or simply the shape of the player's free hand – provides the support necessary for playing a difficult shot. (p.4)

This conceptualises and reinforces the nature of relationships in a spirit that supports AMHP work being seen more explicitly as relational work as well as the potential for a form of advocacy where ‘difficult shots’ might have to be played by any party.

Power and empowerment

Some studies have identified professionals’ reluctance to relinquish power as a factor that undermines SDM (Entwistle et al., 2008). Stress and pressures arise from the perception that AMHPs are ‘agents of social control’ who are challenged to balance the needs of the state, the wider public and the person themselves (Thompson, 2003; Campbell, 2010) and this ‘custodial function’ of the role has been seen as potentiating an inevitable trade-off of values (Chan, 2002). Interestingly, the interviews from this study indicated that service users more than AMHPs were vigilant to ideas of risk and protection of the public[48]. Yet the relinquishing of power doesn’t mean handing over decisional autonomy absolutely.

In mental health settings, power manifests in different ways, including the ways in which professionals determine service users’ very needs and wants (Lukes (2005, p.107) as well as the agenda for discussion (Kaminskiy, 2015) or the very opening of a MHA assessment. Chapter Six in this study addressed the ways in which power is wielded at the micro level of communication, constructed and maintained through conversation and institutional practices. This can also include mere gaze (Foucault, 1997; 1980). The findings from this study indicate a need for a more explicit focus on social epistemics as the ways in which participants in a MHA assessment handle knowledge distributions amongst themselves through the organisation of conversational sequences (Heritage, 2012; Kasper and Wagner, 2014).

Given the work invested in the redistribution of power and floor space within a MHA assessment, it is arguably incongruent that any power sharing ends at the decision-making stage where, typically, AMHPs take the decision-making elsewhere as part of what was termed earlier the ‘kitchen conversation’. I argue here that this is strongly habitual and there is a case for rethinking. Perhaps OD or bridging principles might explicitly address and begin to problematise this it in practice. This might also create a more explicit role for AMHPs as legitimate coordinators, advocates, enablers and brokers of choice rather than, as experienced by service users in Chapter Seven, invisible people who ‘fall into the shadows’.

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[48] This may be because of the ‘risk to self or others’ expression commonly (mis)attributed to MHA assessment.

Disproportionate outcomes and unconscious biases

Outcomes of MHA assessments are understood to be inconsistent, variable and influenced by many factors and, further, the MHA is known to disproportionately affect some groups or to indirectly discriminate (DoH, 2015; DHSC, 2018b). The high rates of detention for people from racialised backgrounds was one rationale for reforming the current MHA. Yet, whilst AMHPs are required to be alert to, and to challenge, discrimination and oppression (HMSO, 2008; DHSC, 2019) they are, as applicants, arguably complicit with this. Focusing on conversation and the role of epistemics may also sharpen a focus on culture and on racism. This includes a recognition that conversational patterns such as turn-taking (one focus of Chapter Six) is not a universal feature of conversation. For example, Thai people converse in almost continual exchanges to which many people contribute simultaneously (Hartmann and Hudak, 2003). Tannen (1981) describes overlapping and simultaneous talk among some Jewish groups and Abrahams (1974) has evidenced the same among certain African and African American groups. Conversational conventions are contextual and culturally determined yet, often, when cultural norms of turn-taking are not observed, the breaker of those covert rules may be viewed as rude or, crucially, as 'symptomatic'. Whilst 'rule-breaking' may be as a result of cultural differences, the history of psychiatry is one of moral judgement (Burnard, 2003) and so it is suggested that the current focus on unconscious bias and disproportionate outcomes for people from racialised groups might do well to focus more specifically on conversational patterns and epistemic asymmetries. Further, a MHA assessment is not a typical conversation given what is at stake for service users and this too needs to be acknowledged.

More broadly, the wider social and cultural environment around service users is thought to have a large and varied effect on the practice of SDM. People from racialised backgrounds perceive less practitioner trust in them and they in turn have less trust in the professionals (NICE, 2021). Other cultural barriers included gender, sexuality and socioeconomic status. Arguably, it is only by addressing micro-relations that the ongoing disproportionate detention outcomes can be addressed, in at least as professionals' understanding of a situation cannot substitute actors' understanding of a situation (Garfinkel, 1967).

AMHP work as emotionally explicit work

The ethnography and interview phases of this research considered the significant factors (including personal, professional and organisational contexts) affecting AMHPs in the decisions they make. No study pertaining to AMHP practice could escape the stress and burnout inherent in the role. This is a consequence of morally injurious work around conditions of austerity and resource restrictions. This is inextricably wrapped up with the nature of the human and relational work that is MHA assessment and detention.

In this study, AMHPs' stress was articulated through their language. The ethnographical phase of this study revealed ways in which AMHPs express their conflict and moral injury through the use of figurative language. When interviewed, AMHPs articulated an acknowledgement of their 'doing terrible things to people', the 'bleaching of events' in their minds or the darkness attached to being a 'grim reaper' or 'psychopomp'. These powerful and visceral descriptions were delivered in matter-of-fact terms or with an apparently humorous tone. AMHPs do not appear to engage with their own trauma arising from the work they do. In their practice generally it was, at times, difficult for AMHPs to communicate their sense of the complex interactions within their work and their language helped to capture its overwhelming and unspeakable aspects (Markmann, 2011). They used metaphoric and figurative language to describe tacit knowledge and experiences, where they have no written references that could explain or validate their feelings or experiences (Weiner, 1999).

AMHP work is emotionally charged work and, arguably, should be explicitly seen as such rather than, at best, a side effect of the work. This again raises a reframing from a culture of legalism or managerialism to a culture of relationships. AMHPs appeared to be wrestling with the idea that a culture of rationality inhibits and spurns a culture of emotional expression where expressing emotions at work is seen as a personal failure to cope rather than as a mark of professionalism (Rajan-Rankin, 2014). One AMHP in Chapter Seven referred to the need to engage a 'stiff upper lip', and that the emotionally difficult aspects of the work or things that you 'just get on with' (p.206). In such a culture, reason is valued more highly with emotion an 'interference' (Fineman, 2000). Ultimately, if the emotional backcloth of organisational culture is one that views high stress levels as an innate aspect of the work, then there is a risk of tolerance to it remaining unchallenged and such stress and alientation becomes normalised (Rose, 2020).

Aspects of 'dirty work' have been considered in relation to ASW and AMHP work (Morriss, 2016; Vicary et al., 2019) with degradation and a wounding of a person's dignity arising from a detention seen as a form of such dirty work (Hughes, 1971). It may also be that AMHPs' actual work runs counter to the more heroic of their moral conceptions where they develop 'collective pretensions' or 'dignifying rationalisations' in order to give the work, and consequently themselves, value (Morriss, 2016). There are ongoing apparent conflicts between AMHPs idealised or preferred professional identities and, again, these have not been evaluated for their practice implications.

Old horizons new futures: MHA reforms

This study suggests that AMHPs' communicative actions need to be acknowledged as methods of *doing* empowerment. This is important not only in terms of practice, but also in terms of statutory reforms where SDM is increasingly being cited. At the time of writing, the MHA is currently being debated and reformed (DHSC, 2021). The Independent Review of the MHA (DHSC, 2018) discussed SDM, pointing to evidence that it is not practised routinely for those subject to the MHA. Themes of epistemic injustice, that service users' knowledge and perspectives are discounted or undermined within decisions about care and treatment, are apparent within the evidence. Arguably, the research findings from this study offer specific opportunities to critically engage with this reform process.

The new guiding principles within the future reforms are understood to be as follows:

- **Choice and autonomy:** ensuring service users' views and choices are respected and represented in Advance Choice Documents, in Care and Treatment Plans and through enhanced opportunities to challenge treatment decisions
- **Least restriction:** strengthening and clarifying the criteria that must be satisfied before a person is detained and treated; ensuring a person is only detained where it is absolutely necessary
- **Therapeutic benefit:** greater consideration must be given to whether, and if so how, detention and interventions provided under the Act are, or would be, beneficial to a person's health and recovery
- **The person as an individual** – ensuring patients are viewed and treated as individuals; supported by enhanced rights to Independent Mental Health Advocates, and through the Patient and Carer Race Equality Framework (PCREF) to address experiences and outcomes for people from black, Asian and minority ethnic backgrounds

'Choice and Autonomy' is the new iteration of the Empowerment and Involvement principle and here, mental health professionals should:

> ensure service users' views and choices are respected and their voices are heard more loudly and distinctly and carry more weight. (p.69)

The new ‘Choice and Autonomy’ principle speaks of a ‘move to mandatory recording of shared decision-making’ in order to improve outcomes, acknowledging that culture change is required to ensure that it becomes routine practice (DHSC, 2018 p.36). Yet if MHA assessments are to be a place for SDM, more needs to be understood about effective techniques and aspects of communication and involvement. There is a gap between policy aspirations and current practice.

Further, the reforms are considering going beyond the current position in that the principles should be within, and at the front of, the body of the Act itself (DHSC, 2018) rather than be just policy within the Code of Practice, as they are currently. This means that they:

> would provide the statutory basis for all actions taken under the Act, setting standards for services, and providing patients with clear expectations for their care and treatment. Our intention is that everyone, including patients and mental health professionals, should have easy access to these principles, and that they should be used to hold services to account and to guide organisations’ approaches. (p.65)

There are recommendations for the use of SDM, as well as the recording as to how this has been achieved. There is, then, a further pressing need to consider how this can be undertaken more effectively and how it can be evidenced more reliably.

A closer reading of the White Paper (DHSC, 2021) suggests that some of this may be achieved through Advanced Choice Documents (ACD) which serve to provide people with:

> the opportunity to set out in advance the care and treatment they would prefer, the name of their chosen nominated person, and any treatments they wish to refuse, *in the event they are detained* under the Act and lack the relevant capacity. (p.33 emphasis added)

The emphasis is on the requirement for ‘clinicians’ to consider the contents of an ACD during hospital detention and, once detained, SDM between ‘clinicians and patients’ should be used to develop Care and Treatment Plans containing all ‘treatment decisions’.

This appears to be concentrated on Autonomy and Choice once a person has been detained in hospital. But what happens before hospital? What of the MHA assessment? As it stands there remain very few choices about *alternatives* to admission, where the choice might be to not be in hospital, or to be in a different hospital, or in a crisis house or something else. The power of the ACD here is as yet unclear and, consequently, so are the powers of the AMHP to address alternatives to hospital in line with the (retained) principle of least restriction.

The choices that begin once someone has already been admitted to hospital appear, as it stands, to be related to medication. Questions arise as to the meaning and influence of ACDs for people who choose not to conceptualise mental distress as being part of an illness framework, as has been the case within this study. An approach such as this one may well serve to maintain a route into hospital (which we already have) and not offer AMHPs and people with lived experience the choices that they would really like to see as a route out of hospital. Fundamentally, if 'treatment' recommendations are offered as incontrovertible medical facts (Ubel et al., 2017) it is not the importance of autonomy that is denied but, instead, it is the *practice* of autonomy that is being mishandled (Schneider, 1998).

The context within which the MHA reform has taken place is one in which there has been a retraction of services as part of a government with neoliberal ideologies and a political economy of austerity. AMHPs are not working in a system with a systemic or political stance of neutrality. From this perspective there can be limited optimism that they will be in any other position than to continue to act with powers that are rhetorical and illusory. Similarly, their experiences of moral injury will continue. Perhaps there now ought to be a reframing of AMHP work as a 'political activity' and perhaps it is time to revisit the work as being a democratising of practice in recognition of an increasing 'psychiatric neglect'. Certainly, it is time to build on AMHP work as relational work.

Implications for training

Chapter Six considered factors that facilitated or impeded service users' participation in MHA assessments. Yet when AMHPs were asked about SDM, or techniques for 'doing' Empowerment and Involvement, there was a general perception that there was a lack of training or evidence-base and a limited understanding as to what these meant in practice. It appeared that in this study, and in keeping with Goossensen et al's (2007) finding, AMHPs generally did not ask meta questions about participation in decision-making and, rather, there was a suggestion that they too intuitively 'feel' if a service user wants to be involved or not. Findings also suggest that methods of empowerment and involvement and SDM are applied in subtle ways in MHA assessments, but that AMHPs do not recognise the application of these explicitly. Indeed, AMHPs recognise that they have no clear textual representation as to how to apply the principles in their practice. This is not part of the professional body or statutory curriculum, despite the policy rhetoric and statutory imperatives around involvement.

Yet AMHPs' understood and mediated their power in different ways, albeit unknowingly. Within a context of MHA assessments, they addressed epistemic asymmetries and empowered service users to be involved in their assessments in different ways. There is, then, a need for a sharper focus on the process of MHA assessments and the communication therein. This can be built upon in their training.

I have introduced many concepts developed from this study as part of my own training with AMHPs as a way of enhancing their practice and report-writing. My experience within training (consistent with the interviews with AMHPs discussed in Chapter Seven) has been that they are not confident around how they apply the relevant practice imperatives and, in particular, how they are consolidated in their mandatory report-writing. They have the practice imperatives but are not sure about models, techniques and considerations. They are also asked to implement the concepts of SDM in an environment that does not necessarily support these changes, with economic and time pressures that do not reward good communication practices (Ubel et al., 2017) as was borne out in the ethnographic phase of the study.

Evidence-based models can be developed through greater vigilance over the role of epistemics and conversational manoeuvres. Training should also focus on the place of attitude shift more broadly into one of seeing AMHP work as relational work. Crucially, however, it must also do so within a broader recognition of AMHPs' 'political activities' and practice priorities.

It has been questioned whether training could also support service users ahead of future MHA assessments (Blakley, 2021). Arguably this should be a deliberate focus as part of Advance Choice Documents, and it may serve to balance what appears to be a heavy focus on 'treatment' as it is typically administered in a hospital setting. Models of SDM certainly vary in the way they position the roles and responsibilities of each party. For example, Towle and Godolphin (1999) suggested that there are competencies required for both professional and service user, whereas others have placed more responsibility on the professional to elicit or respond to people's views (Edwards et al., 2003). Communication interventions for professionals can also address verbal and nonverbal skills to enhance affiliation and the therapeutic alliance (Horvath and Symonds, 1991) and to elicit and respond to service users' concerns (Joos et al., 1996)[49].

Crucially, it has been suggested from research with ASWs that those who feel inadequately trained and supported in the more subtle skills of their own profession may be more likely to defer to practitioners of more highly codified disciplines, such as psychiatry and the law, contrary to the statutory formulations of their own roles (Sheppard, 1995). The current study

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[49] Whilst this research did not include the video-recording of MHA assessments, this is an area of Conversational Analytic research that could be considered as a follow-up. In my own notes I recorded AMHPs' non-verbal approaches (which I have compared with the directing of traffic) to stop some parties from talking and invite others in using hand gestures.

suggested that AMHPs may not even be consciously aware of the ways in which their interventions (particularly through repair) empowers service users to be involved in their assessments and, to an extent, decision-making and so, again, this might constitute the first step towards an evidence-base for the work through making their communicative actions visible.

Reflexivity

From the beginning of this study, I have reflected on whether (or where) I was complicit in any of the subjects of discussion and debate. I know that I have experienced moral dilemmas throughout, including whether I was making judgments about others' practice (in relation to my own) and whether I was inserting my own practice experiences and priorities into the interpretation of data. In some respects, this meant being alert to bias and guarding against it. I wondered whether I had at any point moralised, even merely through the raising of an eyebrow or the pursing of lips, particularly around the 'assessments fast and slow' issue where I immediately thought, upon hearing the phrase, that I am sure I *do* 'piss about' in relation to the duration of my own MHA assessments[50]. I still reflect on whether this is merely style or more morality and judgement. On the other hand, I have considered whether as part of my various AMHP selves my relatively deep immersion in the subject has placed me in a privileged position whereby I was afforded unique insights into the data in that I could quickly conceptualise and reconcile my observations within the different dimensions of AMHP practice.

Essentially, I was acting as curator and making decisions around what to include and what sense to make of these things. I did, however, find the sliding scale between objectivity and subjectivity difficult to navigate. I also deliberately reflected on Fine's (1993) caricaturing of the different types of ethnographer. I tried to be the 'kindly ethnographer' but did not want to conflate this with my 'educator self'. This perception of me only became apparent when an AMHP asked 'how did I do?' following a piece of work and I was taken aback at the question. I was mindful to not unintentionally undermine AMHPs who I knew, and I also was concerned about being thought of as a 'traitor' because of my future writing. This made me try to be the 'friendly ethnographer', which was particularly difficult where there were colleagues with whom, and aspects of practice with which, I struggled as they were in conflict with my own values or decisions. I wanted to be the 'honest ethnographer' but sometimes was not quite

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[50] I later noticed that an indignant or even righteous tone came off the page in my diary notes where had written that '*actually*, this is the 'right' thing to do…'.

sure what I could say with complete honesty about details or discoveries. This continues to trouble me.

Early in this study I came to appreciate how absorbed I am in AMHP matters, albeit that I was not fully prepared for undertaking research in a service and with some AMHPs that I knew. With reflection, I realised I had thought that undertaking an ethnographic project in a field in which I am already immersed (given my 'pre-history') I would confirm or 'find the familiar' (Madden, 2010 p.3). I found, however, that whilst this happened in some areas, in others my assumptions were challenged. Maintaining an ethnographic perspective in a familiar or 'home' setting invited deeper self-reflection and, as Madden (2010) highlights, this can disarm one's sense of being ethnographic:

> Home can be parochial. It is also a place that can elicit an uncritical attachment or the need to defend. It is habitual and old habits of speech, manners, attitudes and moods come back when we return. It can elicit a personality change or, conversely, we become ourselves again. Ultimately, it is a place of ambivalence: problematic, yet attractive. (p.45)

I had expected to see and feel the familiar and thought that I would need to focus on achieving some distance (appreciating that complete objectivity would be impossible). However, I realised that I was perceived as a visitor and, as a researcher, a new 'other'. This felt incongruous as I had assimilated my 'student self' at this stage and considered myself something of a naïve enquirer, a 'learner'. Yet, because of my background I was perceived as somebody who considered that they knew things – the opposite of how I was feeling. I realised that I had taught many of the AMHPs, delivered CPD training to them and was seen as an educator or a colleague yet I was still now perceived as 'other' due to the distinct 'researcher' identity which raised new questions and appraisals for them.

At times, I experienced what I thought was minor resentment towards my presence and my planned study. I reflected on an 'insider' argument such that I could only really understand what was happening if I worked there and experienced what these AMHPs experienced. Fundamentally, I had to continually revisit the motivation that originally brought me to this research, as well as the research imperative to aim for a non-judgemental position which asks that the ethnographer suspends their personal valuations or, at least, guards against the more obvious biases by making them explicit (Fetterman, 2010 p.23). This is one reason why I deliberately tried to follow the advice to read and treat my notes 'as if a stranger wrote them' (Fetterman, 2010 p.23). This was one way to approach the data analysis but I imagine I will continue to wrestle with this aspect of the work, not least as I continue to present it and manage my own reference points as part of my ongoing training with AMHPs.

Further, since the publication of the national plan (DHSC, 2019) and the introduction of Standard Four pertaining to ‘psychological safety’, I have been delivering national training and workshops relating to the traumatic nature of AMHP work along with a recognition of the high levels of stress and burnout inherent in the role. Confronting these aspects of the traumatising nature of the work, as well as the emerging discussions around ‘proper work’, has forced a revisitation of my own AMHP self and practice experiences. I continue to wonder how (or if) I reconciled aspects of this into my work and have recognised my own needs for reflective supervision around this.

Future Research

Despite the private nature of MHA assessments along with the implications for loss of liberty, there has been no previous research relating to the ways in which MHA assessments and decision-making take place. Similarly, there is little to no research in this area which privileges AMHP practice and this would appear to be in need of further investigation, not least given the policy and statutory developments around autonomy, choice and SDM. Structural or individual, subjective approaches to AMHP research have as yet only offered a limited account of professional practice. This may be because approaches to research that focus on only one viewing point miss the target. To develop a meaningful understanding, future research could focus on epistemic asymmetries in terms of power. The degree of epistemic congruence in MHA assessments (measured by displays of empathy and alignment) could be the central target (Kasper et al., 2010). Research incorporating the views of service users are an essential part of this not least as professionals’ understanding of a situation cannot substitute or even represent all actors’ understanding of a situation (Garfinkel, 1967).

Interaction-based operationalisations of all the key themes within this research are yet to be developed but a method such as Conversation Analysis highlights precisely how interactions work and what role language plays. Practitioners can ‘see’ their own practices, what happens, what works, and what constitutes effective communication by ‘freezing the analytic frame’ on practice (Stivers, 2005). Research based on recollections through interviews or case vignettes rather than detailed empirical cases inevitably glosses over the fine detail of what actually happens in these encounters (Schegloff, 1988). It would be impossible to interpret the subtle forms of manipulation and control applied in the construction of ‘sharing’ decisions.

The findings from Chapter Five highlighted that understanding AMHPs’ stress and burnout may begin with ostensibly mundane aspects of the environment, such as hot-desking or other temporary surroundings which in fact may be undermining or removing AMHPs’ peer supervision including support with difficult or upsetting events (Biggart et al., 2016). These settings offer no opportunity to make sense of and challenge situations of ambiguity and moral complexity with colleagues (White, 2014). This was highlighted by many AMHPs who found that isolation and lone work from the COVID-19 pandemic lockdown was a final straw (Hemmington et al., 2021).

AMHPs appear to be wrestling with their various identities and there is a lack of clarity as to what makes a 'proper AMHP' or a 'good AMHP'. There is a pressing need to address if, or how, service restructures and apparent emerging hierarchies, with 'assessments fast and slow', are affecting the ways that AMHPs work. Future studies could also include the ways in which AMHPs' language provides a window into their experiences (Camp et al., 2020), not least as a way of addressing the ongoing high levels of stress, burnout and attrition. Importantly, AMHPs' language conveyed aspects of empathic failure which returns the emphasis to the need to consider meaningful coproduction in service development and practice (DHSC, 2019).

The phrase 'meaningful coproduction' is of itself a further training, research or reflection need within AMHP settings. This again pertains to a conceptualisation of AMHP work as democratised practice. Dzur (2018) refers to democratic professionals as being reform-minded innovators within their field. Specifically, they are:

> democratic professionals not because they do democracy professionally but because they do professionalism democratically. (p.1)

Closer consideration could be given to the ways in which AMHPs can enact their professional AMHP work more democratically as part of coproduction or, indeed, empowerment and involvement. Elsewhere, Dzur (2020) notes that 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. Secondly, professionals have played a major role in labelling leading to stigma and alienation. In all these ways, even as they have tried to help, professionals have created institutions that can be profoundly disempowering for citizens.

For Ostrom (1996) coproduction is not citizens going it alone and nor is it top-down coordination of community involvement by professionals. Rather, the ideal is a horizontal playing field in which respect and power are more evenly divided. In this respect, coproduction becomes a democratic, relational process. Arguably, AMHPs interventions in MHA assessment were aimed at creating such a horizonal perspective.

Chapter One asserted that politically, SDM is allied with the growth in agendas such as personalisation, choice and competition in service delivery and as such it also reflects a broader policy orientation towards the neo-liberalisation of health and social care (Glasby, 2012). Yet arguably it can also be allied to a more radical democratisation impulse. This duality might also mirror, and explain, the apparent paradoxes and dilemmas of AMHPs servicing an ostensibly oppressive system but holding to a (more radical?) social perspective.

AMHPs in this study spoke in clear terms about their close proximity to burnout and their moral injury arising from the lack of meaningful alternatives to admission (or, indeed, therapeutic hospital settings that people might choose to be in). In this respect, AMHPs and service users alike bear the brunt of the neoliberal politics of austerity and managerialist approaches to their service settings. The national AMHP workforce plan (DHSC, 2019) speaks of services being co-produced with services and arguably this too necessitates a fundamental revisitation as to 'who we are for'.

Overall, findings from this research highlight the ways in which AMHPs communicate with and relate (or indeed fail to relate) to service users as part of their decision-making. This research has provided a source of practice-based evidence that can inform current understandings by illustrating communication practices not previously considered or described in theoretical models or practice guidance. Future research must draw more robustly from research exploring both AMHPs' and service users' subjective positions, values (personal, professional and political) and experiences. This would also provide an interesting comparison to the current study.

This research would be usefully extended by continuing to focus both on AMHP settings, including the apparent divergence of full-time and part-time work in what is ostensibly the same role. It may also be meaningful to undertake a similar, scaled-up study to potentially include the significance of non-verbal communication.

Dissemination and plans for change

To come full circle to my Natural History and my AMHP Educator selves, the findings of this study are beginning to be delivered to AMHPs as research-informed training, and AMHPs are starting to reflect on the locus of power within their assessments. This is part of looking ahead to statutory reforms, where AMHPs will also need to be better prepared for accounting, in writing, for how they have embedded their statutory imperatives around empowerment and involvement or autonomy and choice. SDM techniques and the forthcoming reforms to the MHA speak of a 'move to mandatory recording of shared decision-making' in order to improve outcomes, acknowledging that culture change is required to ensure that it becomes routine practice (DHSC, 2018 p.36). As part of my ongoing AMHP Policy-Maker self, future plans are to further evaluate the impact of restructuring AMHP services and to focus on the impact of findings from this study.

Limitations

The study was relatively small-scale and as such may be considered a pilot study or foundation for future work, or in order to offer comparison with future findings. Nevertheless, a substantial amount of fieldwork and analysis has been accomplished in the various stages of the research.

The study did not incorporate AMHPs' written reports, but it would be interesting to further understand how AMHPs articulated these relatively theoretical concepts in their written accounts of the assessment.

As discussed above, in terms of my own natural history I am engaged in AMHP practice and have some familiarity with AMHPs in this study, their service, their qualifying experience and my interpretations may, at times, reflect this. I do not necessarily see this as a limitation, but a level of reflexivity is essential.

As discussed earlier, I had planned from the start to develop a level of subjective criticality and to try to be deliberative about my practitioner-research self. I developed techniques such as setting out from the start what I saw as being pre-formed ideas and expectations as to what I might find. As described earlier, after discussing this with colleagues I made a discernible shift from thinking I should minimise or exorcise my practitioner self to something that I needed to critically engage with.

I realised that my presence could have influenced my findings in different ways. I could tell from AMHPs' language and attitudes that they saw me differently. For example, a previous student of mine asking 'how did I do', or one or two attempts to check decision-making which made me realise that I was not being seen as a researcher. I realised that some AMHPs felt as if they needed to be 'on their toes' and this made me uncomfortable (and perhaps even judgmental as to whether their practice would be somehow less deliberative were I not there!). It is possible that AMHPs, knowing the purpose of my study was to look at Empowerment and Involvement or SDM, might practice differently in terms of wanting to evidence something I could see. Additionally, at least one AMHP did not coordinate their assessment in their usual way as they referred (or, potentially, deferred) to me once or twice in the assessment. As part of the ethnography, some AMHPs might have been more vociferous to make their point and have it on record; others may have been less confident in speaking.

I also reflected on, and indeed struggled with, what felt like a position of liminality, in that I was somewhere in-between practitioner and researcher, from where I was trying to reconcile professional and research ethics[51]. Inevitably, there will be an impact on the confirmability as well as transferability of my findings and any future research I might undertake will require me to bear this in mind. Such is the impact of these tensions, I have subsequently (and very possibly consequently) become more aware of, and involved in, aspects of practitioner-research in the AMHP world.

Practitioner-research

Practitioner-research is understood as a form of enquiry which people undertake in their own working context and, usually, on their own professional work (Dadds and Hart, 2001). Its purpose is to shed light on aspects of that work with a view to bringing about some benevolent change. It is a way to take on the challenges of the work by practitioner-researchers studying practices carefully (along with their communities) to aim to improve their situations (Dadds, 2008). However, practitioner-research has been seen as a 'fringe' activity, or a minor form of research, by traditional researchers and policy makers and practitioner-researchers have felt constrained by ideas about 'expert' (academic) knowledge which has led to feelings of disempowerment for many who devalue their personal knowledge, experience and professional voice (Dadds, 1998). Ultimately, there is a culturally inherited view that practitioner-researchers are not doing 'real research' (Dadds, 1998). My diary notes engage with my proximity to 'real research', and whether my insider/outsider status enhanced or undermined this throughout the duration of the project.

Towards the end of the research, possibly exacerbated by the changes I had made as a consequence of the COVID pandemic, I reflected at length on the size of the project which, at times, I referred to as feeling unwieldy. I asked questions such as:

> *This feels huge … what to include or prioritise? Was this about my FOMO? Is it because I am wearing too many hats?*

This included what to keep in and what to exclude when I was writing my thesis. I re-engaged with the idea that my own self was a subjective resource on which to capitalise, and I reflected on the fact that I might be excluding this at the expense of what I saw as being more 'formal' or important findings. My conceptual framework had developed throughout the project, and it

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[51] I reflect on my being motivated, in several areas, by a sense of lack in terms of ways to make sense of my experiences.

was a challenge to try to get the balance right between what I had retained and what I had excluded.

This all required a continual ‘checking-in’ with my conceptual framework and the research rigours attached to this. I had found the ethnography, against my expectations, to be an essential part of the project to the extent that, on reflection, I could have made it a more robust and detailed aspect of the project. Spending time with AMHPs in this way had enabled me to learn about real-life challenges, including ones with clear policy and practice implications. I do not think that I could have learned about this using any other method. Similarly, observing and recording MHA assessments had enabled me to address my research questions as findings at the level of fine-grained analysis, such as Conversation Analysis, had picked up on areas of practice that before did not seem as visible to the naked eye.

Following these assessments with interviews allowed me to understand AMHPs’ positions and contexts which, when considering the ethnography as a form of ‘provenance’ helped to make sense of some of the organisational and professional contexts. This was similar in some ways to hearing the voices of service users who, in addition to being provided with a debrief, were invited to have their voices heard in a way that the literature suggests is usually absent. Hearing peoples voices and understanding the ‘meaning making’ is also consistent with a social constructionist methodology which I tried to engage with throughout.

Wrestling with what I had identified as the ‘unwieldiness’ and ‘cosmic proportions’ of the research as I was trying to draw it together in one thesis (whilst sticking to a word count which I often thought needed to be twice as long) did make me reflect on whether I had tried to take on too much. However, it is only with the benefit of hindsight and having done the research and sat with the findings that I could understand what was credible, of value, transferable and meaningful. This is a deliberation I take with me as a consider what, if anything, I might want to write for any future audience.

Transferability

I have considered what meaning this study might have. Qualitative researchers often make reference to the trustworthiness of the research, which is to ask ‘can the findings to be trusted?’ (Lincoln and Guba, 1984). For Lincoln and Guba, one way to consider trustworthiness is to address the level of transferability, defined as ‘the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents’ (p.117). This is facilitated through the researcher's quality and depth of description. It also means to not just describe participant's behaviour and experiences, but their context as well so that the behaviour and experiences become meaningful to an outsider (Korstjens and Moser, 2018). Transferability concerns the applicability of the research to enable the reader to assess whether findings are transferable to their own setting, and it is therefore the reader who makes the 'transferability judgment' as I, as researcher, am not familiar with their specific settings. This underpinned many aspects of the research, including my earlier decision to undertake an ethnographic study, to inform the meaningfulness of the interview process and topics as well as decisions about settings and participant samples. It also made my ongoing reflexivity key in that I was continuously present within the collecting, analysing and interpreting of data.

Smith (2018) makes a comparison with transferability and the concept of generalisability which is used within quantitative research and statistical-probability generalisation. Stake (1978) speaks of 'naturalistic generalisability', sometimes also referred to as representational generalisation (Lewis et al., 2014). Here, generalisability is reached on the basis of recognition of similarities and differences to the results with which the reader is familiar and so in that sense it overlaps with transferability, outlined above. It happens when the research resonates with the reader's personal experiences. I am not able to predict whether the research in this study is going to resonate with any AMHPs' experiences – the knowledge and findings are contingent – I can only suggest that this study has the *potential* to be meaningful in certain ways (Chenail, 2010). Smith (2018) suggests that readers may be able to think with the results and not just about them. In so doing, readers might reflect on how transferable the research is or isn't.

Original contribution to knowledge

This original, detailed ethnographic study with AMHP services provided a new refined and detailed focus on the ways in which environments exert an influence on AMHP practice. Despite service restructures at a national level, there is yet to be any research or evaluation of the emerging, different modes of delivery for AMHP services and their impact on decision-making. The AMHP function has ostensibly stayed the same, yet this study found significant social and political forces shaping aspects of the work. There was an emerging picture of power struggles and fissures that had not been anticipated as part of the restructures and is not hitherto apparent in the literature. New existential questions, fundamental to AMHPs' identities, as to what constitutes a 'proper AMHP' and who AMHPs are *for,* were being asked. This research explored, for the first time, whether AMHP work continues to be a values-driven venture with advocacy being a fundamental aspect or whether approbation and 'good practice' was attached to a need for speed.

AMHPs language provided a window into their experiences, an important finding in relation to the ongoing challenges for recruitment and retention being affected by high levels of stress, burnout and attrition. This study focused on the nature of AMHP work and moral distress or moral injury, highlighting that AMHPs do not appear to engage with the inherent trauma despite emerging policy imperatives focusing on their psychological safety.

Within mental health research, the focus on power has generally been on the overt, structural or 'macro' aspects of control and coercion. This is the first detailed piece of research to privilege the AMHP role in terms of the MHA assessment and the communicative practices and distribution of power therein. Research to-date has not included observation, audio-recording and the use of Conversation Analysis as a method of understanding interactional exchanges as they actually occur. Research based on interview recollections or case vignettes glosses over the fine detail of what actually happens in the moment. Practitioners can now 'see' their own practices which they may hitherto have taken for granted.

This research highlighted the ways in which AMHPs' coordinating roles extend into the assessment. AMHP work was visible as a form of empowering relational work with trainable techniques. Viewing the relational aspects of the work as a conceptual resource sharpens the focus as well as opening this area of practice to greater scrutiny.

Finally, there is very little research around service users' experiences of MHA assessments as the majority of knowledge relates to experiences in hospital. Overall, the knowledge and insights that were generated critically engage with and contribute to current statutory reforms requiring SDM and its mandatory recording. This research has highlighted effective techniques and aspects of communication and involvement to fill this gap.

Conclusion

There is a statutory, policy-based and professional rhetoric encouraging (and potentially mandating) empowerment and involvement, SDM, self-determination, and autonomy and choice but there is also a simultaneous diminishing of resources. Observations and techniques may support AMHPs to achieve communicative practices that are conducive to the rhetoric of involvement, but it is likely that resourcing issues will remain unchanged or will even deteriorate and, in this sense, AMHPs themselves are similarly powerless. It is, then, time for AMHPs to revisit the questions of identity, values and 'who they are for' and how to build on this as a political activity.

AMHPs perceive their independent role as advocacy-based and they view their power struggles with medical colleagues as a way of operationalising this. They may, then, reflect on their positioning and the nature of the relationship they have with service users and colleagues so that they come out of ‘the shadows’. Perhaps they could consolidate their ‘AMHP work as political’ stance, with their self-defined collective noun as ‘necessary irritant’, and aspire to the creation of a system that is relational and, as far as is possible, consensual. After all, any encounter is, in part, a creation of the ideas that professionals bring to their work. If AMHPs’ position is that they have a ‘burning desire for things to be fair’ and that ‘you’re with this person against the system’ (Hemmington et al., 2021 p.58) then they are well placed to address this. Both AMHPs and service users experience a high level of distress arising from the MHA assessment scenario. For AMHPs, there is a high level of moral injury attached to their ongoing inability to do their main job of avoiding detention for people they assess. This is not, to borrow from one AMHP’s ‘Top Trumps’ analogy (p.185), to say that one is worse than the other. AMHPs need to continue to be able to undertake this work in a way that enables connection with the person at a human, relational level. Ultimately, AMHPs and service users are injured by the same thing: a lack of meaningful resources and choice at times of acute distress.

Ultimately, participation and control are matters of perception. Sharing decisions equally may mean different things to different people. In general terms the trend to place decision-making responsibility with the person, when embedded within a political context of severe restrictions on resources, risks a form 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. Certainly, increasing experiences of moral injury do seem to be indicating a pendulum swing in this direction.

This research has privileged the AMHP’s position and vantage point in MHA decision-making. Findings of the study were considered along with a recognition that there are significant social and political forces that shape aspects of AMHP work and, it seems, the assessment itself. Service users’ positions also came to the fore, both within the assessment scenario and more broadly in terms of alternatives to admission. This research, by considering the viewing points and perspectives of both parties, highlights what is at stake for service users as they navigate the mental health system and, specifically, as the subjects of AMHPs’ decision-making around detention.

Within mental health settings, the focus on power has generally been on the overt, structural or ‘macro’ aspects of control and coercion but evidently AMHPs can continue to focus more explicitly and deliberately on the more subtle forms of manipulation at the ‘micro’, individual level of negotiated decisions and the space between two people. This also means that AMHPs openly acknowledge and deliberately attend to their coordinating role being one that extends into and throughout the assessment. In some respects, AMHPs’ professional self-perception and self-concept rests on the language of advocacy enacted and embodied through the professional relationship. This study suggests that AMHP work could, therefore, more explicitly be considered to be relational, where AMHPs can formalise and legitimise their coordinating, empowering and involving role, potentially becoming a broker of choice (Kasper et al., 2010).

Compulsory detention may still be necessary at times but, as service users in this study suggested, there is scope to have hospitals and crisis services that people might choose to go to. Conversely, AMHPs may be facing the prospect of tackling increasing psychiatric neglect. Overall, the position may be summed up by a person with lived experience of MHA assessment and detention:

> I know that your time is limited, pressured, and precious, but taking my autonomy is life changing and I need your time, effort, and humility to counterbalance that power and to fight for the rights I have. (Anonymous, 2017)

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Appendices

Appendix 1: Statutory Competences for qualifying and post-qualified AMHPs

STATUTORY INSTRUMENTS

2008 No. 1206

MENTAL HEALTH, ENGLAND

The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008

Made - - - -	*28th April 2008*
Laid before Parliament	*7th May 2008*
Coming into force - -	*3rd November 2008*

SCHEDULE 2

Regulation 3(2)

Matters to be taken into account to determine competence

1. Key Competence Area 1: Application of Values to the AMHP Role

Whether the applicant has—

(a) the ability to identify, challenge and, where possible, redress discrimination and inequality in all its forms in relation to AMHP practice;

(b) an understanding of and respect for individuals' qualities, abilities and diverse backgrounds, and is able to identify and counter any decision which may be based on unlawful discrimination;

(c) the ability to promote the rights, dignity and self determination of patients consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty, and

(d) a sensitivity to individuals' needs for personal respect, confidentiality, choice, dignity and privacy while exercising the AMHP role.

2. Key Competence Area 2: Application of Knowledge: The Legal and Policy Framework

(1) Whether the applicant has—

(a) appropriate knowledge of and ability to apply in practice—

(i) mental health legislation, related codes of practice and national and local policy guidance, and

(ii) relevant parts of other legislation, codes of practice, national and local policy guidance, in particular the Children Act 1989(**c**), the Children Act 2004(**d**), the Human Rights Act 1998(**e**) and the Mental Capacity Act 2005(**f**);

(b) a knowledge and understanding of the particular needs of children and young people and their families, and an ability to apply AMHP practice in the context of those particular needs;

(c) an understanding of, and sensitivity to, race and culture in the application of knowledge of mental health legislation;

(d) an explicit awareness of the legal position and accountability of AMHPs in relation to the Act, any employing organisation and the authority on whose behalf they are acting;

(e) the ability to—

    (i) evaluate critically local and national policy to inform AMHP practice, and

    (ii) base AMHP practice on a critical evaluation of a range of research relevant to evidence-based practice, including that on the impact on persons who experience discrimination because of mental health.

(2) In paragraph (1), "relevant" means relevant to the decisions that an AMHP is likely to take when acting as an AMHP.

3. Key Competence Area 3: Application of Knowledge: Mental Disorder

Whether the applicant has a critical understanding of, and is able to apply in practice—

(a) a range of models of mental disorder, including the contribution of social, physical and development factors;

(b) the social perspective on mental disorder and mental health needs, in working with patients, their relatives, carers and other professionals;

(c) the implications of mental disorder for patients, their relatives and carers, and

(d) the implications of a range of treatments and interventions for patients, their relatives and carers.

4. Key Competence Area 4: Application of Skills: Working in Partnership

Whether the applicant has the ability to—

(a) articulate, and demonstrate in practice, the social perspective on mental disorder and mental health needs;

(b) communicate appropriately with and establish effective relationships with patients, relatives, and carers in undertaking the AMHP role;

(c) articulate the role of the AMHP in the course of contributing to effective inter-agency and inter-professional working;

(d) use networks and community groups to influence collaborative working with a range of individuals, agencies and advocates;

(e) consider the feasibility of and contribute effectively to planning and implementing options for care such as alternatives to compulsory admission, discharge and aftercare;

(f) recognise, assess and manage risk effectively in the context of the AMHP role;

(g) effectively manage difficult situations of anxiety, risk and conflict, and an understanding of how this affects the AMHP and other people concerned with the patient's care;

(h) discharge the AMHP role in such a way as to empower the patient as much as practicable;

(i) plan, negotiate and manage compulsory admission to hospital or arrangements for supervised community treatment;

(j) manage and co-ordinate effectively the relevant legal and practical processes including the involvement of other professionals as well as patients, relatives and carers, and

(k) balance and manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other persons concerned with the patient's care.

5. Key Competence Area 5: Application of Skills: Making and Communicating Informed Decisions

Whether the applicant has the ability to—

(a) assert a social perspective and to make properly informed independent decisions;

(b) obtain, analyse and share appropriate information having due regard to confidentiality in order to manage the decision-making process including decisions about supervised community treatment;

(c) compile and complete statutory documentation, including an application for admission;

(d) provide reasoned and clear verbal and written reports to promote effective, accountable and independent AMHP decision making;

(e) present a case at a legal hearing;

(f) exercise the appropriate use of independence, authority and autonomy and use it to inform their future practice as an AMHP, together with consultation and supervision;

(g) evaluate the outcomes of interventions with patients, carers and others, including the identification of where a need has not been met;

(h) make and communicate decisions that are sensitive to the needs of the individual patient, and

(i) keep appropriate records with an awareness of legal requirements with respect to record keeping and the use and transfer of information.

Appendix 2: Summary of Data from Ethnography (Spradley Chart)

Adapted from Spradley (1980) and Robson (2002) 9 Dimensions of descriptive observation	
9 dimensions	**Theme / example from data**
SPACE: *Layout of the physical setting; rooms, outdoor spaces, etc.*	FT AMHP Hub – flashing lights/clock, speed and urgency; hotdesking
	Localities – some rural; green and leafy; slower pace; owned desks with colleagues; ‘owned’ by CMHT;
	Environments – creepy lanes
ACTORS: *Names (anonymised) and relevant details of the people involved*	FT AMHPs: More assessments; faster pace, ‘don’t piss about’; legalistic
	PT AMHPs: Fewer assessments; slower pace; frustrations
	Styles: Legalistic; Value-based; Emancipatory; Pragmatic; Organisational; personal value base; advocacy-based; Identities: Person-centred; social work; legal roles; professional; organisational (including LA/Trust) More or less autonomy; Hawks and doves
	Language: clinical/medical/social/emancipatory; trauma
	Assessments fast and slow
	Health/trust AMHPs and liminality
ACTIVITIES: *Various activities of the actors*	Carrying habits around; debates around identities (FT and PT); competing and opposing views; shared dislike of Trust/health systems and ‘hierarchies’; Following the people and following the thing Organisation not operating as expected from restructure Discussions/debates around ‘good AMHP and ‘proper AMHP’
OBJECTS: *Physical elements: furniture etc.*	Hotdesking – no personal items around/comforts/territories Timekeeping clock
ACTS: *Specific individual actions*	Communication – Metaphor and metonymy particularly to articulate frustration/pain/distress – articulating the unsaid particularly re: organisational identity and conflict and orientational markers
	Tension, frustration and anger between each other - hierarchies
	Moving between teams and settings – chameleon-like; boundaries; links to united against health systems
EVENTS: *Particular occasions, e.g. meetings*	County AMHP meetings / local team meetings Training events – different approaches / interpretations Difference between ethnography / Rapid Ethnography
TIME: *The sequence of events*	RE – developing service
	Assessments fast and slow – timing and duration of assessments
	Power - Negotiating hierarchical power; battle for cultural capital: Status, novices, amateurs and experts:

GOALS: *What actors are attempting to accomplish*	Hub AMHPs - always “on it”, asking fewer questions of themselves/others Power with others – showing rank? Cultural and professional capital FT AMHPs - Burden of Responsibility? Controlling, allocating, managing the work of others and negotiating a power-based hierarchy; autonomy? Allied to SUs? AMHP compared their own sense of being valued with SUs – bottom the pile - work was not accounted for, and its existence only became apparent through talking; Find identity – no accounting for this - textually non-existent. Mapping the social relations of power within local contexts and ruling relations; hierarchies not sanctioned by local policies, organisations or institutions; dissonances;
	Understanding perceptions of peer support
FEELINGS: *Emotions in particular contexts (theirs)*	Distress, guilt and moral injury – articulated through metaphor/metonymy Upset and angry with each other
	Models of stress/explanations - socially organised through meetings? Consistent stress associated with resources/beds/doctors Devaluation of PT work – tacit incorporation of stress into the work Affective state influencing decisions? “I dread being on duty; I feel professionally compromised”
ORGANISATIONAL:	Practical frustrations; resources; conveying, bed availability; alternatives Organisational constraints and lack of resources leading to feelings of frustration, anger and fatigue and cynical or critical thinking Organisation’s risk aversive position leading to thoughts around blame and criticism; thinking around this can appear defensive and defended Autonomy – others organising the work CMHT; CRHTT not getting involved now We’re a LA we just bend over Assessments being allocated – how many/who allocates; prioritising – organisational and individual and getting ‘tangled up’; legal frameworks around them? Moral/ethical – if it’s a breach then it is.
	EDT and Team differences
	Time and workload
	‘Real’ AMHP role – not just conveying/not talking to doctors/donkey work
MY HISTORY/SELVES: Field relationships (mine with AMHPs); my emotions	Motivation that brought me to this and implications Non judgemental approach? Moralising/judging/pissing about The One That Went Wrong Pre-history selves Insider/outsider

Appendix 3: Participant Information Sheets and Consent Forms

Form 1: AMHP Information Sheet

Title: A study of the factors affecting Approved Mental Health Professionals' Decision-Making

Jill Hemmington: AMHP and Doctoral Student

What is the research?

Research indicates that outcomes of Mental Health Act assessments are variable. Different AMHPs may arrive at different decisions, but there is very little research about the factors influencing these decisions. This research is looking at how AMHPs make decisions about hospital admissions or community support for people they assess, considering any variables such as professional background, or demographic differences.

The research is ***not*** about whether your decision is the right or wrong one – it is understood that you apply your own professional judgement to any situation. The research is about *how* the decision is made, rather than what it is. AMHPs consider many variables when making their decisions and it would be helpful to know more about this. This will help with training future AMHPs to think about the decisions they make and arrive at their own outcomes.

Who is organising the research and why?

This study is a PhD research study. It is research to enable AMHPs to learn more and think about how decisions about care and treatment are made.

What does the research involve?

Participation in the study is entirely voluntary.

If you give permission, I would like to spend time with your AMHP service, observing and developing a greater understanding of some of the organisational and environmental factors that influence practice. This will mean that I can develop an appreciation of the areas of significance for AMHP work. I may be taking notes, but I am happy and willing to share these at any stage of the research process.

The research also involves observations of up to 15 Mental Health Act assessments. If you give your permission, I may approach you to be present in the room during one or more of these assessments. I will not be assessing or interviewing the service user. I am interested in the conversations you and the service user have with each other. You do not have to do anything differently. I will make notes about my observations and with permission, the assessment will be audio-recorded and then transcribed. Following the assessment, you will be invited to participate in a brief interview to allow me to understand and clarify your perspective. You may be asked for an opinion as to whether the service user has capacity to consent to take part in the research.

Who will have access to what I have said?
Everything that is said or written will have your identity changed to ensure that it is protected.

What will the information be used for?
Information about the assessment process will be used in my thesis and might be published in academic journals. No personal details, including your name and work address, or that of the service user, will be revealed and identities will be kept anonymous. All electronic information will be safely and securely stored. The research will also be conducted in line with Lancashire Care Foundation Trust and the relevant Local Authority's confidentiality policies.

What if I change my mind?
You have the right to withdraw at any time within four weeks of your assessment. After this point it will not be possible to identify data relating to your assessment.

What are the possible benefits of taking part?
You may not directly benefit from taking part in this study, but the information will help us better understand how AMHPs make their decision. It is hoped that the data collected will inform practice and training for future AMHPs.

What are the possible disadvantages and risks of taking part?
You are not asked to do or say anything differently, and I will aim for a discreet, shadowing approach so as to minimise any disturbance. It is accepted that there may be some slight inconvenience, but it is hoped that you will consider taking part in order to be involved in research to highlight practice matters, including good practice. If you decide not to take part, or withdraw, this will not affect your employment.

Service users who have experienced Mental Health Act assessments themselves have been consulted in the planning of this research.

Thank you for taking the time to read this information sheet.

- **Researcher Contact Details: Jill Hemmington; 01772 895460; JHemmington@uclan.ac.uk**

If you are unhappy or have concerns about any aspect of the project, and do not wish to contact the research team, you can contact the University Officer for Ethics (Email: officerforethics@uclan.ac.uk) who is entirely independent of the research and will

respond to your concerns. Other forms of contact for University Officer for Ethics are telephone 01772 892735 and postal address is Ethics and Integrity Unit, Research Services, Foster Building FB033, UCLan, PRESTON PR1 2HE

How your information is protected:
UCLan is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCLan will keep identifiable information about you for up to four weeks after the research has taken place.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting https://www.uclan.ac.uk/data_protection/access_your_information.php and/or JHemmington@uclan.ac.uk

The researcher will collect information from you for this research study in accordance with our instructions. The researcher will keep your name and contact details confidential and will not pass this information to UCLan. The researcher will use this information as needed, to contact you about the research study. UCLan will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. UCLan will keep identifiable information about you from this study up to four weeks after the research has taken place. All anonymised, non-identifiable data will be destroyed within five years.

How the information will be used:

No identifiable data will be shared by the researcher. No names will be recorded, and all participants will be assigned a code to identify them. All audio recordings will be anonymised and transcribed within 4 weeks and then destroyed. Only contact details will be kept for 4 weeks for the purposes of arranging a follow-up debrief and interview. All anonymised transcriptions will be destroyed within five years following the study. The recording of assessments will be on a hand-held digital recorder, but will be downloaded to a secure, password-protected UCLan PC immediately. All recordings will be deleted from the digital recorder prior to leaving the building. No names will be recorded, and anonymous codes will be assigned to each saved file.

Form 2: AMHP Consent Form (Ethnography)

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making

Jill Hemmington: AMHP and Doctoral Student

AMHP Name: ______________________________

Please initial box

I have had the opportunity to ask questions about the study and I understand what is involved. ☐

I understand that anonymised excerpts may be used for publications and/or teaching materials. ☐

I give my consent for my work to be observed. ☐

I give my consent for the observer to make notes ☐

Name of AMHP: ____

Date: ____

Signature: ____

Researcher Signature _____________________________ Date ______________

1 copy to be given to participant

1 copy for the investigator file

1 copy is for the medical records

Form 3: AMHP Consent Form (MHA Assessment Observation)

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making

Jill Hemmington: AMHP and Doctoral Student

Participant Identification Code: ______________________

AMHP Name: ______________________________

Please initial box

I [name] have been informed about the nature of this research project. I have had the opportunity to ask questions about the study and I understand what is involved. ☐

I understand that the assessment will be audio recorded and transcribed ☐

I understand that anonymised excerpts may be used for publications and/or teaching materials ☐

I give my consent for the assessment to be observed and notes taken ☐

I give my consent to be interviewed following the MHA assessment and for this interview to be audio-recorded ☐

I understand that I have the right to withdraw at any time within four weeks ☐

Name of AMHP: ___________________________ Date: _______________

Signature: ____

Researcher Signature ______________________________ Date ______________

1 copy to be given to participant
1 copy for the investigator file
1 copy is for the medical records

Form 4: Service User Information Sheet

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making

Jill Hemmington: AMHP and Doctoral Student

I am Jill Hemmington. I work at the University of Central Lancashire. I will show you my identification including photograph and I am happy to answer any questions about the research.

I'd like to invite you to take part in a research study. Joining is entirely up to you, but before you decide I would like you to understand why the research is being done and what it would involve for you. I will explain this information leaflet to you and answer any questions you might have. This should take about 5 minutes. Please feel free to talk to others about this study if you wish. Please do ask if anything is unclear.

Service users who have experienced Mental Health Act assessments themselves have been consulted in the planning of this research.

What is the research?

This research is looking at Approved Mental Health Professional (AMHP) practice, and how the AMHP makes their decision about hospital admissions or community support for people they assess. The AMHP is part of the assessment and along with the doctors they make decisions about your care and treatment, and whether this needs to be in hospital.

AMHPs consider many things when making their decision and sometimes they do things differently. We do not know a lot about this, and it would be helpful to know more. This will help with training future AMHPs to think about the decisions they make.

Who is organising the research and why?

This is research for a PhD. It is research to enable AMHPs to learn more and think about how decisions about care and treatment are made.

You have been invited to take part because a Mental Health Act assessment has been arranged for you. I will be the only researcher, and anyone else involved is part of the care team.

What does the research involve?

You do not have to take part in this research project but if you give permission, I would like to be present in the room whilst you are being assessed. I will not be assessing you and will not need to ask you any questions. I am interested in the conversations you and the AMHP have with each other. You do not have to do anything differently – the research is to help understand how the AMHP makes their decision about your care and treatment.

I will be present until the assessment has finished. I will make notes about my observations of the AMHP and the way that they practice – but these notes will ONLY be about the AMHP and nothing else. The assessment will be audio-recorded so that I have an accurate record of the AMHP's practice.

Up to two weeks following the assessment, I will be asking your permission for me to contact you for a brief interview so that I can make sure that I understand your experience. This will also allow you to ask questions and be given information and I will again check that I have your consent to go ahead with the research. This should last from 30 minutes to one hour and with your permission will be audio-recorded so that I do not miss any important information.

Who will have access to what I have said?
Everything that is said or written about you will have your name and location removed to ensure that your identity is protected. I will not share information from the research with anyone else except my supervisory team and this will not include any identifying information about you.

What will the information be used for?
Information about the assessment process will be used in a written research thesis and might be published in academic journals. No personal details will be recorded. Your identity will be changed to ensure that it is confidential and only I as researcher will have access to this information. All electronic information will be safely and securely stored. The research will also be conducted in line with Lancashire Care Foundation Trust and the Local Authority's confidentiality policies.

The research does not affect your treatment or influence the AMHP's assessment. If you decide not to take part, or withdraw, this will not affect your care, support or treatment.

What if I change my mind?
You have the right to withdraw at any time within four weeks of your assessment. After this point it will not be possible to identify information from your assessment from that of others' assessments.

What are the possible benefits of taking part?
You may not directly benefit from taking part in this study, but the information is extremely helpful to understand how the AMHP made their decision. It will also help inform practice and training for future AMHPs.

What are the possible disadvantages and risks of taking part?
You are not asked to do or say anything to the researcher as it is the AMHP who will be being observed. You may wonder what will be written, and you are welcome to read any material that is written or published from this study. A final information sheet will be available for this. There are no disadvantages or risks directly to you.

Should you feel upset, or should you wish to share any important or upsetting information, you are encouraged to share this with the AMHP and care team who will arrange the necessary support.

Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

Thank you for taking the time to read this information sheet.

Researcher Contact Details: Jill Hemmington; 01772 895460; JHemmington@uclan.ac.uk

If you are unhappy or have concerns about any aspect of the project, and do not wish to contact the research team, you can contact the University Officer for Ethics (Email: officerforethics@uclan.ac.uk) who is entirely independent of the research and will respond to your concerns.

Other forms of contact for University Officer for Ethics are telephone 01772 892735 and postal address is Ethics and Integrity Unit, Research Services, Foster Building FB033, UCLan, PRESTON PR1 2HE

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Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting https://www.uclan.ac.uk/data_protection/access_your_information.php and/or JHemmington@uclan.ac.uk

The researcher will collect information from you for this research study in accordance with our instructions. The researcher will keep your name and contact details confidential and will not pass this information to UCLan. The researcher will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from UCLan and regulatory organisations may look at your medical and research records to check the accuracy of the research study. UCLan will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

UCLan will keep identifiable information about you from this study up to four weeks after the research has taken place. All anonymised, non-identifiable data will be destroyed within five years.

How the information will be used:
No identifiable data will be shared by the researcher. No names will be recorded, and all participants will be assigned a code to identify them. All audio recordings will be anonymised and transcribed within 4 weeks and then destroyed. Only contact details will be kept for 4 weeks for the purposes of arranging a follow-up debrief and interview. All anonymised transcriptions will be destroyed within five years following the study.

The recording of assessments will be on a hand-held digital recorder, but will be downloaded to a secure, password-protected UCLan PC immediately. All recordings will be deleted from the digital recorder prior to leaving the building. No names will be recorded, and anonymous codes will be assigned to each saved file.

Form 5: Service User Consent Form

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making

Jill Hemmington: AMHP and Doctoral Student

Participant Identification Code: ___________________________

Please initial box

I have been informed about the nature of this research project. ☐

I have had the opportunity to ask questions about the study and I understand what is involved ☐

I understand that the assessment will be audio-recorded and transcribed ☐

I understand that anonymised excerpts may be used for publications and/or teaching materials ☐

I give my consent for the assessment to be observed and notes taken ☐

I give my consent to be interviewed and for this to be audio-recorded and notes taken ☐

I understand that I have the right to withdraw at any time within four weeks of the assessment.

Signature: _________________________________ Date: ________________

Anonymised Participant Code: __________________ Date: ________________

Researcher Signature ____________________________ Date ________________

1 copy to be given to participant
1 copy for the investigator file
1 copy is for the medical records

Form 8: General Information Sheet (for all non-AMHP/non-Service User participants)

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making

Jill Hemmington: AMHP and Doctoral Student

Background to Research

Research indicates that outcomes of Mental Health Act assessments are variable. Different Approved Mental Health Professionals (AMHPs) may arrive at different decisions, but there is very little research around this. This research is looking at how the AMHP makes their decision about hospital admission or community support for people they assess.

The research is ***not*** about whether the decision the right or wrong one – it is understood that the AMHP applies their own professional judgement to any situation. The research is about *how* the decision is made, rather than what it is. AMHPs consider many variables when making their decisions and it would be helpful to know more about this. This will help with training future AMHPs to think about the decisions they make and arrive at their own outcomes.

This is a PhD research study. It is research to enable AMHPs to learn more and think about how decisions about care and treatment are made.

Participation in the study is entirely voluntary.

If you give permission, I would like to be present in the room during the assessment. I will not be assessing or interviewing the service user. I am interested in the conversations that the AMHP and service user have with each other. You do not have to do anything differently. I will make notes about my observations of the AMHP and the assessment will be audio-recorded and then transcribed. This recording will be destroyed once the research is complete.

You may be asked to take part in discussions as to whether the service user has capacity to consent to take part in research.

Information about the assessment process will be used in my thesis and might be published in academic journals. No personal details, including your name and work address, or that of the service user, will be revealed and identities will be kept anonymous. All electronic information will be safely and securely stored. The research will also be conducted in line with Lancashire Care Foundation Trust and the Local Authority's confidentiality policies. All information will be destroyed when the research is completed.

You have the right to withdraw at any time within four weeks of the assessment. After this point it will not be possible to distinguish between assessments as these will have been anonymised.

What are the possible benefits of taking part?
You may not directly benefit from taking part in this study, but the information is extremely helpful to understand how the AMHP made their decision. It is hoped that data collected will help inform practice and training for future AMHPs.

What are the possible disadvantages and risks of taking part?
You are not asked to do or say anything differently, and the researcher will aim for a discreet, shadowing approach so as to minimise any disturbance. It is accepted that there may be some slight inconvenience, but it is hoped that you will consider taking part in order be involved in research that will highlight practice matters, including good practice.

Service users who have experienced Mental Health Act assessments themselves have been consulted in the planning of this research.

Thank you for taking the time to read this information sheet.
Researcher Contact Details:
Jill Hemmington; 01772 895460; JHemmington@uclan.ac.uk

If you are unhappy or have concerns about any aspect of the project, and do not wish to contact the research team, you can contact the University Officer for Ethics (Email: officerforethics@uclan.ac.uk) who is entirely independent of the research and will respond to your concerns.

Other forms of contact for University Officer for Ethics are telephone 01772 892735 and postal address is Ethics and Integrity Unit, Research Services, Foster Building FB033, UCLan, PRESTON PR1 2HE

How your information is protected:
UCLan is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCLan will keep identifiable information about you for up to four weeks after the research has taken place.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting https://www.uclan.ac.uk/data_protection/access_your_information.php and/or JHemmington@uclan.ac.uk

The researcher will collect information from you for this research study in accordance with our instructions. The researcher will keep your name and contact details confidential and will not pass this information to UCLan. The researcher will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded and to oversee the quality of the study. Certain individuals from UCLan and regulatory organisations may look at medical and research records to check the accuracy of the research study. UCLan will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out names, NHS numbers or contact details.

UCLan will keep identifiable information about you from this study up to four weeks after the research has taken place. All anonymised, non-identifiable data will be destroyed within five years.

How the information will be used:
No identifiable data will be shared by the researcher. No names will be recorded, and all participants will be assigned a code to identify them. All audio recordings will be anonymised and transcribed within 4 weeks and then destroyed. Only contact details will be kept for 4 weeks for the purposes of arranging a follow-up debrief and interview. All anonymised transcriptions will be destroyed within five years following the study.

The recording of assessments will be on a hand-held digital recorder, but will be downloaded to a secure, password-protected UCLan PC immediately. All recordings will be deleted from the digital recorder prior to leaving the building. No names will be recorded, and anonymous codes will be assigned to each saved file.

Form 9: General Participant Consent Form

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making
Jill Hemmington: AMHP and Doctoral Student

Participant Identification Name: ___________________________

Name: _______________________________

Please initial box

I [name] have been informed about the nature of this research project. I have had the opportunity to ask questions about the study and I understand what is involved.	☐
I understand that the assessment will be audio recorded and transcribed.	☐
I understand that anonymised excerpts may be used for publications and/or teaching materials	☐
I give my consent for the assessment to be observed and notes taken.	☐

I understand that I have the right to withdraw at any time within four weeks of the assessment.

Name: ____________________________ **Date:** __________________

Signature: ____

Researcher Signature _________________________ **Date:** __________________

1 copy to be given to participant

1 copy for the investigator file

1 copy is for the medical records

Form 12: Service User Consent Form (Interview)

Title: A study of the factors affecting Approved Mental Health Professionals' Decision Making
Jill Hemmington: AMHP and Doctoral Student

Participant Identification Name: ___________________________

Please initial box

I [name of Participant] have been informed about the nature of this research project. I have had the opportunity to ask questions about the study and I understand what is involved ☐

I give my consent to be interviewed and for the interview be audio recorded ☐

I understand that anonymised excerpts may be used for publications and/or teaching materials ☐

I understand that I have the right to withdraw at any time within four weeks of the assessment. After this point, the assessment will already have a code number and it will not be possible to identify this observation from others' assessments.

Name of Participant _______________________ **Date** ___________

Researcher Signature ________________________ **Date** __________________

1 copy to be given to participant
1 copy for the investigator file
1 copy is for the medical records

Appendix 4: Jeffersonian Transcription Key

Conversation Analysis Transcription Key

A. Some aspects of the relative timing of utterances	
[ ] square brackets	Overlapping talk
= equals sign	No discernible interval between turns
(0.5) time in parentheses	Intervals within or between talk (measured in tenths of a second)
(.) period in parentheses	Discernable interval within or between talk but too short to measure (less than 2 tenths of a second)
<	'jump' started talk
B. Some characteristics of speech delivery	
Punctuation symbols are designed to capture intonation, not grammar and are used to describe intonation at the end of a word/sound, at the end of a sentence or some other shorter unit:	
. period	Closing intonation
, comma	Slightly rising intonation (a little hitch up on the end of the word)
? question mark	Fully rising intonation
- dash	Abrupt cut off of sound
: colon	Extension of preceding sound – the more colons the greater the extension
here underlining	Emphasised relative to surrounding talk
CAPS	Increased amplitude (loudness)
.tch or .t	Tongue click
hhh.	Audible outbreath (number of h's indicates length)
.hhh	Audible inbreath (number of h's indicates length)
>Talk<	Speeded up talk
<Talk>	Slowed down talk
#	Croaky or creaky voice
£ or $	Smiley voice
Hah hah or huh huh etc.	Beats of laughter
( ) empty single brackets or words enclosed in single brackets	Transcriber unable to hear words or uncertain of hearing
((word)) words enclosed in double brackets	Transcribers' comments
↑↓	Marked change in pitch

Atkinson J. Maxwell and Heritage John (eds) (1984) *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press**.**

Jefferson, G. (2004). Glossary of transcript symbols with an Introduction. In Lerner, G.H. (ed) *Conversation Analysis: Studies from the first generation*. Philadelphia: John Benjamins. pp. 13-23.

Appendix 5 (i): AMHP Interview schedule

AMHP Interview Schedule:

1. How did you feel about being on duty that AMHP day?

2. What did you think about this assessment generally?

3. Is there anything in particular that sticks in your mind?

4. Your decision was …. What do you think influenced or informed this?

5. Did you see any other possible outcomes? *[Follow up – obstacles?]*

6. Do you have any thoughts on the role of the other professionals? Did they act into this role in a way that you expected?

7. AMHP practice is said to be affected by resource issues: does this influence your practice?

8. Do you think you were able to bring your 'social perspective'? How?

9. Did you/do you feel as though your role is independent? Are you in charge/control of your work and your decision-making?

10. Do professional/personal backgrounds make a difference to AMHP work? Why?

11. How do you know/feel that that you have done a 'good job'/the 'right thing'?

12. Do you feel safe in your work? Do you feel afraid or at risk, for whatever reason?

13. What sort of support do you think/feel you need? Where might this come from?

14. How would you describe the role to other people? Do you think that other people understand what the AMHP role and AMHP work is?

15. One of the Guiding Principles is about 'Empowerment and Involvement': service users should be 'fully involved in decisions about care, support and treatment'. Did this principle apply to your assessment? If so, how? If not, obstacles?

16. Shared Decision Making is a formal, interactive process to share information and opinion, discuss service user preferences and professionals' responsibilities, and build consensus to reach an explicit agreement.
    a. Do you think this is possible within a MHA assessment, and if not what are the obstacles?

17. How do you understand what service users' priorities are?

18. How do you know if a service user wants to participate in the decision-making or not?

19. What is the hardest part of your AMHP role?

20. What do you enjoy about the role?

Appendix 5 (ii): Service User Interview schedule

1. What happened before the assessment?
    a. Did you feel/think that you needed help? If so, what?

2. What has been happening since the assessment?

3. Did it feel like an 'assessment'?

4. Did you have any expectations?

5. Is there anything in particular that sticks in your mind?

6. Which MH professionals were there?

    a. Did it feel like they talked to you/supported you/approached the problem differently? Did it feel like anyone was on your side? Do you any of the MH them having a differing/conflicting remember approach to each other?

    b. Did they act into this role in a way that you expected?

7. The decision was …. What do you think influenced or informed this?

    a. Did you see any other possible outcomes? *[Follow up – obstacles?]*

8. Do you think they did 'right thing'? If not, why?

9. Did you feel safe? Or afraid or at risk, for whatever reason?

10. What sort of support do you think/feel you need? Where might this come from?

11. One of the Guiding Principles is about 'Empowerment and Involvement': service users should be 'fully involved in decisions about care, support and treatment'. Did this principle apply to your assessment? If so, how? If not, obstacles?

12. Shared Decision Making is a formal, interactive process to share information and opinion, discuss service user preferences and professionals' responsibilities, and build consensus to reach an explicit agreement.
    a. Do you think this is possible within a MHA assessment, and if not what are the obstacles?

13. How do professionals understand what your priorities are?

14. How could/would you participate in the decision-making?
    a. Did this happen?

15. What was the hardest part of what happened?

16. Was there anything helpful that came out of it?

17. Thinking about life before/after the assessment, has it changed things? If so, how?

Appendix 5 (iii): Service User Interview schedule national research project

Service User Interview for Social Work England research (Hemmington et al., 2021)

Person with lived experience interview schedule:

- ***Introductions and explain purpose and format of the interview, consent to participate, confidentiality and right to withdraw***
- ***Explain recording of the interview and data storage***
- ***Each interview should last up to an hour and be recorded on Microsoft Teams***
- ***Questions to be introduced one at a time with up to 5 minutes for each question***
- ***The interview is semi-structured and guided by the interviewer and interviewee***
- ***The interviewer may interject to ask questions, seek clarity, refocus but avoid suppressing information***

<u>Questions (Experiences of AMHPs)</u>

1. Can you tell me how much or how little you know about Approved Mental Health Professionals (AMHPs) and what their job involves?

2. Can you tell me about your experiences with AMHPs?
   (assessment and intervention)

3. What did you think about the assessment(s) generally and how it made you feel?

4. What was the AMHP like? (Helpful and unhelpful)

5. What was the outcome of your assessment(s)?
   a. What do you think influenced or informed this?
   b. Did you see any other possible outcomes?

6. Did you feel as though you were involved in the decision making?

7. Do you think they could have handled things in a better way?

8. What do you think AMHPs need to know more of? (Explore training/education)

9. Do you know if the AMHP was a social worker, nurse, psychologist or occupational therapist?
   a. Do you think that it would it have made any difference (explore differences in practice)
   b. Do professional/personal backgrounds make a difference to AMHP work? (only explore if known/appropriate)

10. Is there anything important that I have missed/anything else you'd like to tell me/any questions before we close?

Appendix 6 (i) Thematic Analysis summary tables: AMHP interviews

Interviews with AMHPs	
Superordinate Themes	Key issues arising within the theme
Power and Authority	➢ Multidisciplinary power struggles o Doctors o Other colleagues ➢ Advocacy and rights-based approach ➢ Service users' lack of power ➢ Associations with morality/ethics power 'for good'
Autonomy and Independence	➢ Links to power and assertiveness ➢ Problematic/intimidating/isolating ➢ Compromises with AMHP service ➢ Compromises with other colleagues
Social perspectives/models	➢ Variable interpretations/application o Social determinants o Resources o Social constructionist ➢ Power/challenge/confrontation ➢ Reference to identity
Organisational issues	➢ References to restructure ➢ Workload including no. of assessments ➢ Relationships/support ➢ Part-time and Full-time AMHP differences ➢ AMHPs' invisibility
Resources	➢ Hospital beds (lack of) ➢ Alternatives to admission (lack of) ➢ Links to guiding principles/professional imperatives ➢ Moral injury/distress/guilt/anxiety
Emotions, stress and health	➢ References to physical/mental health ➢ Fear/anxiety/injury ➢ Abuse/injury from others ➢ Uncertainty ➢ Ambivalence / continuing to practice
Status, prestige and enjoyable aspects of the AMHP role	➢ Status/authority ➢ Discrete pieces of work ➢ Ownership/mastery ➢ Agency/autonomy ➢ Time/listening/therapeutic/crisis work
AMHPs and Shared Decision-Making	➢ Interpreting person's capacity ➢ Limited time to embed SDM ➢ Linked to resources/limited choice ➢ AMHP's role/coordination
Empowerment and Involvement	➢ Lack of dialogue/time/engagement ➢ Understanding/definition/reporting ➢ Where – behind the scenes etc ➢ Communication within the assessment
Support and Leadership	➢ Support from peers/colleagues ➢ Role of managers/supervisors
AMHP practice styles	➢ Being assertive ➢ Legalistic/bureaucratic approaches
Decision-making and uncertainty	➢ Decision-making ➢ Styles

Appendix 6 (ii) Thematic Analysis summary table: Service User interviews

Interviews with Service Users	
Superordinate Themes	Key issues arising within the theme
Emotional effects and the impact on the self	➢ MHAAs as disempowering and dehumanising ➢ Stigma, exclusion, marginalisation, shame ➢ Oppression, intimidating, MHAA pressures
Power and Coercion	➢ Feeling criminalised ➢ Oppression/coercion/threat generally ➢ Soft coercion – limited choices
Fatalism and a lack of control	➢ False perception of choice ➢ Powerlessness re: decision-making ➢ 'Patient' identity with no control or agency ➢ Resistance is futile
Resources	➢ No alternatives to admission ➢ No support to avoid situation e.g. crisis services
Jargon, language and being judged	➢ Infantilising language ➢ Keeping quite to avoid being judged
Paternalism	➢ Others making decisions ➢ Professionals knowing what's best/parentalism
Shared Decision-Making	➢ Being involved (or not) ➢ Having a rationale for decision-making ➢ Communication inviting contribution/reciprocity ➢ Listening and empathy ➢ Kitchen conversation
Empowerment and Involvement	➢ Communication/types of questions ➢ Inclusion
Relationships	➢ Empathy/rapport/being heard/listened to/wamth ➢ Relationship as vehicle for decision-making ➢ Trust
AMHP visibility	➢ Recognising presence/role of AMHP ➢ AMHP as decision-maker/independence ➢ AMHP's practical role
Ambivalence	➢ The 'right thing' ➢ Perceptions of 'help' ➢ Agreeing/disagreeing with decision
Theories, models and perspectives	➢ Orientation to social/clinical/stress explanations ➢ Epistemic domains

Appendix 6 (iii) Thematic Analysis summary table: National Service User interviews

Re-interrogation of national data: Interviews with Service Users	
Superordinate Themes	Key issues arising within the theme
Emotional effects and the impact on the Self	➢ Trauma, fear, dread ➢ Loss of control/agency
The perception of MHA assessment and detention as a threat	➢ Hard and soft coercion ➢ Detention used as threat ➢ Fatalism/loss of control
Ambush	➢ Themes of attack and surrender ➢ Lack of involvement in planning/process
Shared Decision-Making and Communication	➢ Involvement in assessment/decision-making ➢ Communication methods – helpful and unhelpful ➢ Lack of choice – Blake accompli ➢ Sense of foreclosure re: decision-making ➢ Lack of time taken to listen ➢ Lack of transparency ➢ Empathy
Power and coercion	➢ Hard and soft coercion ➢ Communication ➢ Links to ambush
The 'Kitchen Conversation' revisited	➢ Secrecy, exclusion, decision-making elsewhere
Independence	➢ Awareness of AMHP role ➢ AMHPs' presence and visibility ➢ AMHPs' assertiveness and contribution
AMHP work as relational work	➢ Styles – caring, compassionate, warmth, trust ➢ Advocacy; working 'with' ➢ Being treated as human ➢ Relationships before and after the assessment ➢ Seeing the 'person'
AMHPs' and service users' perspectives and models	➢ Social determinants/social constructionism ➢ Resources ➢ Differences to other professionals/clinical perspectives ➢ Cultural interpretations
Resources	➢ Lack of alternatives to admission ➢ Difficulties with focus on the medical/hospital
AMHPs' workload and time	➢ Perceptions of limited time and 'rushing' ➢ Not sharing time/information ➢ Impacts on communication
AMHPs' stress and burnout	➢ Observations of AMHPs' stress and burnout ➢ Expressing sympathy with AMHPs
AMHPs, advocacy and rights-based approaches	➢ Lack of congruence with AMHPs' perceptions of advocacy ➢ Lack of awareness of AMHP role ➢ Experiences of advocacy ➢ AMHP as political ➢ AMHP having no influence
Ambivalence	➢ Mixed emotions about the 'right decision' ➢ Detention as saving life ➢ Experiences of patenalism
Experiences of hospital	➢ Hospitals as unpleasant and un-therapeutic ➢ AMHPs' lack of understanding and knowledge of hospital