“Role over” or roll over? Dirty work, shift, and Mental Health Act Assessments.

DOI:
10.1093/bjsw/bcz014

Document Version
Accepted author manuscript

“Role over” or roll over? Dirty work, shift, and Mental Health Act Assessments.

Sarah Vicary, Alys Young & Stephen Hicks.

Abstract

The rise in numbers of applications for people being formally detained in hospital is one of the reasons given for the independent review of the Mental Health Act in England and Wales (Department of Health and Social Care, 2017). These figures have led to concerns that the legislation might be flawed including in relation to the process of Mental Health Act Assessments. Discussed in this article are two of the roles involved: the doctor who is responsible for conducting a medical assessment and the Approved Mental Health Professional (AMHP) who is responsible for assessing the social circumstances and in addition making the application. Using data from a study into AMHPs and the lens of the sociological theory ‘dirty work’ (Hughes 1971) we discuss shift, an aspect of dirty work not yet applied in this context. We focus on AMHPs’ perceptions of the behaviour of doctors as encapsulated in the verbatim phrase “role over.” We argue that AMHPs, including social workers, justify or, to play on the words of the verbatim quote, roll over. This finding adds to the understanding of behaviour as it is understood within psychiatric occupations, including social work, during Mental Health Act Assessments.

Key words: AMHP, dirty work, IPA, Mental Health Act Assessments, shift

Introduction

The rise in numbers of applications for people being formally detained in hospital is one of the reasons given for the independent review of the Mental Health Act in England and Wales (Department of Health and Social Care, 2017). These figures have led to concerns that the current mental health legislation as it applies in England and Wales might be flawed. Discussed in this article are two roles that have separate statutory remit in the detention process: the doctor, and the Approved Mental Health Professional (AMHP). The doctor may already know the person, through being their General Practitioner for example, or are appointed under section 12 of the Mental Health Act, 1983 (Department of Health para 14.74). Their remit is to make a medical assessment of the person's mental health and to recommend hospital admission, either for assessment or treatment (Department of Health, 2015 para 14.73). Two such recommendations are normally required. In addition, the responsibility for securing a hospital bed is that of a doctor (Department of Health, 2015, para. 14.77). The AMHP is a reconfigured role created following a previous review of the Mental Health Act in England and Wales (Department of Health, 1999) and although now broadened out to mental health nurses, occupational therapists and psychologist, once approved, was previously an exclusive social work function. AMHPs assess the social circumstances and make the formal application for detention, or they can decide not to do so (Department of Health, 2015 para.14.49).

In this article we discuss findings taken from a study of AMHPs one aim of which was to examine the experience of undertaking Mental Health Act Assessments from the perspective of AMHPs, including social workers (Vicary, 2016). We focus on one set of

findings concerning AMHPs' perceptions of the behaviour of doctors. As encapsulated in the verbatim phrase "role over," AMHPs discuss being abandoned by doctors during the assessment process and sometimes even beforehand. Using the lens of the sociological theory 'dirty work' (Hughes 1971) we discuss shift, an aspect of dirty work not yet applied in this context. AMHPs show frustration at being abandoned but despite blocking some attempts by doctors to shift work (their second perception of the behaviour of doctors) AMHPs instead provide a justification. To play on the verbatim quote, they roll over.

These findings add to the understanding of behaviour as it is understood within psychiatric occupations, including social work, specifically during Mental Health Act Assessments. The authors argue that it indicates a fundamental weakness in the current process since it suggests a narrow understanding by doctors, places AMHPs from all professional backgrounds under unnecessary pressure (imagined and real) and may result in a poor experience for the person being assessed, all of which warrants re-examination and, considering the independent review, is timely.

Literature review

Despite opening the AMHP role to other non-medical professionals, statistics show that social work remains the dominant profession (General Social Care Council, 2012, ADASS, 2018). Much of the published literature on professional identity and role of social workers relates to the former incarnation of the AMHP in England and Wales, the Approved Social Worker (ASW), and has three foci: skills, knowledge and individual impact.

A significant analysis and discussion of the skills required by ASWs is presented by Quirk *et al*., (2000) and, to a lesser extent, Davidson and Campbell (2010) and include coordination and advocacy. Data from several studies also indicate that to accomplish being an ASW there is a need to employ inter-personal skills (Quirk *et al*., 2000, Bowers *et al*., 2003). Professional knowledge, the second focus of the literature, attracts debate; some commentators claim that social workers lack knowledge both of mental health symptoms and of legal processes (Fakhoury and Wright, 2004) and others, because the work is seen as an especially problematic activity, suggest that it requires special knowledge and training (Fisher *et al*., 1984, Haynes, 1990). There have been several studies examining ASW training which together suggest varied impact; some view it as lacking in quality (Bowers *et al*., 2003, Christian, 1995, Haynes, 1990), others as good (Campbell *et al*., 2001). One commentator recommends it to other non -social work professionals because of its quality and especially its focus on the work in a less narrow legalistic or medicalised way (Walton, 2000).

The third focus of the literature concerns impact on the individual. There is a consensus among researchers that being an ASW has negative consequences This includes physical (Bowers *et al*., 2003, Davidson and Campbell, 2010) and emotional harm (Huxley *et al*., 2005, Evans *et al*., 2005, Evans *et al*., 2006, Hudson and Webber, 2012, Buckland, 2016). In direct contrast, what also emerges is that the work is viewed by those who undertake it in a positive way. This includes that it is interesting and dynamic (Gregor, 2010) and that it involves complexity such as dealing with contrasting and competing demands (Quirk *et al*., 2000). Last, the ability to effectively manage the therapeutic relationship is discussed in the context of coercion (Hurley and Linsley, 2007).

To date, the inter-relationship between professional background and accomplishment of the AMHP role has not been widely investigated although studies are beginning to emerge in relation to motivation (Watson, 2016, Stevens *et al*, 2018) and the influence of professional skills and knowledge (Bressington *et al*., 2011) albeit this is contested. For example, of primary importance to AMHP work, as it was previously, is the social perspective, a principle based on seeking least restrictive alternatives to hospital and assessment of all circumstances of the case, including a person's social environment. It is argued that this perspective is the domain of social work (Fisher *et al*., 1984, Sheppard, 1990) and that what needs to be accomplished requires a social work background (Walton, 2000, Hatfield, 2008). However, others contend that the role is discrete and by implication can be undertaken irrespective of profession (Myers, 1990). There is also increasingly the suggestion that the social perspective is illusory (Prior, 1992, Gregor, 2010). This article sets out to add to the literature on AMHPs and focusses on the relationship between AMHPs (including social workers) and doctors during Mental Health Act Assessments.

What follows is an appraisal of the dirty work literature as it pertains to psychiatric occupations, including social work. The research design of the study is outlined, and the methods of data collection are explained. Last, the analysis process is described, including how themes emerged and its quality and validity. Verbatim quotes and excerpts from participants' drawings, either whole or in part, are used to illustrate the findings.

Dirty work and psychiatric occupations

The concept of 'dirty work' (Hughes, 1971) is used in the sociological literature to explain the moral dimension of work. It concerns the behaviour of those with supposed higher status seeking to specialise in the most desirable elements of work and involves transferring the least desirable aspects to, usually, inferior others. However, transfer is not always possible, and, in such circumstances, workers justify having to do that work which is least desired, either by exaggerating its importance or its moral aspects (Hughes, 1971). Published literature to date supports the assertion that dirty work is integrated into the whole [occupation] and that any occupations, including psychiatric ones, have "ambiguities and apparent contradictions in the combination of duties" (Hughes, 1971 p. 309). The foremost of these ambiguities is that the worker continues to undertake the work even though they may object to it morally. In so doing they justify the work or dignify it for themselves. Justification, in effect launders dirty work into that which is perceived by the people who are required to do it as clean.

Dirty work as explored in most research concerning psychiatric occupations discusses justification. An early study in America (Emerson and Pollner, 1976) examined the behaviour of emergency mental health workers dealing with compulsory admission (Emerson and Pollner, 1976). This act of compulsion was viewed as *doing to* but signalled for participants a failure of therapeutic intervention or *doing for*. Workers were undertaking what they deemed to be the less desirable aspects of their role but did it nonetheless and in the act of so doing legitimised it for themselves. Meanwhile, in the United Kingdom, another study exploring the Approved Social Worker (ASW) role, the predecessor to the AMHP, described

the anomalous nature of the work as dirty (Quirk *et al.*, 2000). This analysis was reportedly questioned by participants who expressed their disquiet at reference to their work in this way. This was justified by the researcher who suggested that it would be disconcerting if an ASW simply acted in matter-of-fact way with no mention of the morally dubious dimension of the role (Quirk, 2008). Furthermore, its perceived dirtiness is also legitimised when he goes on to suggest that ASW work can also be therapeutic (Quirk, 2008). More recently, dirty work has been applied to data obtained from a study of social workers in community mental health teams who were also AMHPs (Morriss, 2014). This study, too, demonstrates justification when participants were shown to perceive AMHP work as a positive or therapeutic intervention and saw themselves as having status, thereby also dignifying it (Morriss, 2015).

But, as we have seen dirty work also involves shift, usually attempted by those with perceived higher status, or professional standing, who transfer work to others with a perceived lower status (Hughes, 1971). A study into psychiatric occupations in England acknowledges this aspect of dirty work but first, in much the same way as others, its participants are shown to categorise work they perceive as not therapeutic as dirty and in the act of doing so justify it (Brown, 1989). However, shifting routine psychiatric tasks to others is also evidenced; workers perceiving themselves of a higher occupational standing are shown to transfer menial work to others with perceived lower occupational standing (Brown 1989). The justification for doing so is made by the workers doing the shift, through status.

In this article we discus shift as it is shown to occur during Mental Health Act Assessments but justification of it comes from those who are subject to it and not by the occupation doing the shifting. This is a different understanding of this aspect of dirty work. The literature to date that applies dirty work to psychiatric occupations omits to explicitly identify the transfer of work that is perceived as dirty to others, the second aspect of dirty work. Shift, as we are referring to it, is the focus of this article.

Research Design

Methodology

Based on the methodology Interpretative Phenomenological Analysis (IPA) (Smith, 1996), this article uses data from a study of AMHPs, one objective of which was to examine the experience of undertaking Mental Health Act Assessments from the perspective of AMHPs, including social workers (Vicary, 2016). Through IPA, participants are asked to make meaning of an experience that has significance for them, in this instance carrying out Mental Health Act Assessments and the sense made of this as a comprehensive lived experience by participants. Based on three theoretical influences of phenomenology, idiography and hermeneutics, IPA is used to explore a phenomenon in depth using interpretation (Larkin *et al*., 2006, Reid *et al*., 2005, Shinebourne, 2011, Smith, 2004, and Smith *et al*., 2009, Smith, 2007). In turn, the meaning, or interpretation, the researcher makes of the participant's sense-making in that circumstance is undertaken, a process known as the double hermeneutic (Smith and Osborn, 2003).

Sample and ethical approval

The original intention of the study had been to achieve a sample of five participants from each of the eligible AMHP professions. However, at the time of access no psychologists had been approved and just eight occupational therapists (of whom four were accessed and two agreed to participate). The full sample, all practising AMHPs, was therefore made up of five social workers (three male and two female), five nurses (two female and three males) and two occupational therapists, both female. Ethical approval was obtained from a University, from the Association of Directors of Adult Social Services in relation to the social workers who were employed by different local authorities, and from each of the different health trusts employing the nurses and the occupational therapists. Participants were provided with an information sheet during access explaining the purpose and the protocols around matters such as protection of data and anonymity. They were also given an exemplar and guidance about Rich Pictures, one of the data collection methods.

Data were gathered in two ways; a semi- structured interview and a drawing, or Rich Picture, produced by the participant. The interview took place once in a work location and at a time of the participant's choosing. Immediately before the interview the participant information sheet was revisited with the participants who were then asked to sign a consent form. Participants were advised that they could withdraw this consent up to the point of analysis. For IPA, using a less prescribed, semi-structured interview is said to facilitate elicitation of thoughts and feelings allowing the participant to answer questions at their own pace with prompts but no rigid structure (Smith *et al*., 2009, p. 56). Rich Pictures involve the production of a drawing by the subject to represent a complex phenomenon using symbols

and words (Checkland, 1980) which in this study is the participants' experience of carrying out Mental Health Act Assessments. Drawing is said to use different cognitive processes than being asked to reflect through talking, thereby providing opportunity to access thoughts, feelings and emotions in an alternative way (Guillemin, 2004, Kearney and Hyle, 2004). Drawing was also favoured because of its simplicity and tangibility; the only requirement is a pen and paper and once produced the drawing provides a focus for conversation (Matthews, 2013).

Participants were provided with one sheet of white A4 paper and a black ink pen and afforded up to ten minutes alone immediately before the interview to draw their Rich Picture which they were then asked to describe during the interview. Each interview was audio-recorded on a tablet and later transcribed. Photographs were taken of the individual Rich Picture and both the transcripts and photographs were imported into a computer software programme for managing data. Analysis was undertaken of the transcribed text only. Each of these stages were undertaken by the same individual over a period of two years affording in-depth immersion into the data. Once housed within the software package, the analyst used its tools; first, to code the transcripts and then to create a memo for codes and themes that were emerging to the analyst as significant. Each memo contained the reflections as they were occurring thereby allowing an audit trail, a process that also enacts the double hermeneutic. Both are crucial for demonstrating how themes have emerged and to which evidence they are linked and in turn quality and validity in IPA, a fuller explanation of which is published separately (Vicary *et al.,* 2017).

The discussion of findings uses verbatim text and excerpts of Rich Pictures to illustrate. Our question is whether role, or roll over is satisfactory occupational behaviour, including from social workers as AMHPs.

Findings

Encapsulated in the verbatim phrase "role over", doctors are shown in the perception of AMHPs to abandon the assessment once their role is finished. One male nurse refers to this behaviour as the doctors "doing their bit" and then leaving, none of which is a surprise to him:

> *we discussed at that time that it was going to be section 2 [of the Mental Health Act] so what I've got there then is kind of the doctors then did their bit and left, which they tend to do. (Nurse 01)*

This participant goes on to refer to this as the equivalence of the doctor's role being over, albeit he questions this behaviour in his reflections but does not do so with the doctor:

> *I've put role over question mark because for me it seems to be that once that decision's made it is, we can now go we can leave that situation. The AMHP's left with it with whoever else is left sometimes you know you are left with the service user. (Nurse 01)*

He also depicts this in an excerpt of his Rich Picture:

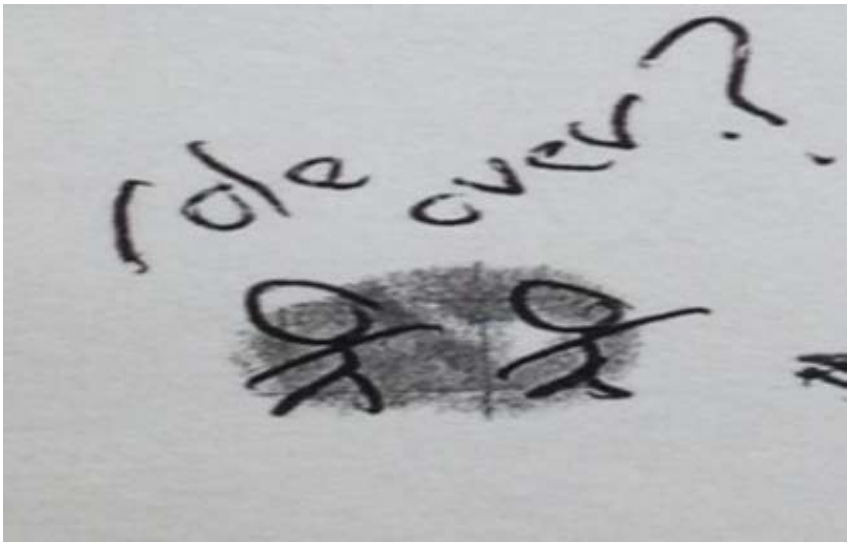

Figure 1." role over" (Vicary et al., 2017, p. 9.)

This same nurse acknowledges that, whilst he respects his medical colleagues, he is unhappy at being abandoned. For him, this behaviour indicates a lack of involvement in the process as well as of responsibility on the doctor's part:

> *It's role over for them. Respectfully, they've been part of that overall application, the AMHP makes the application but they've had to make that recommendation before we can do anything with that. But that for me just seems to be, that's been it from day dot even when I remember kind of going back years…….what I'd say is that I think there should be a bit more of a responsibility to actually feed more into the process with them, the reassuring side of things. (Nurse 01)*

Being abandoned during a Mental Health Act Assessment is an experience not exclusive to nurse AMHPs. One female occupational therapist also describes it:

> *The consultant had left, because often what we [AMHPs] do is we do the assessment, this is fairly typical. (Occupational Therapist 02)*

This excerpt of her Rich Picture shows the smiling face of the doctor as they leave:

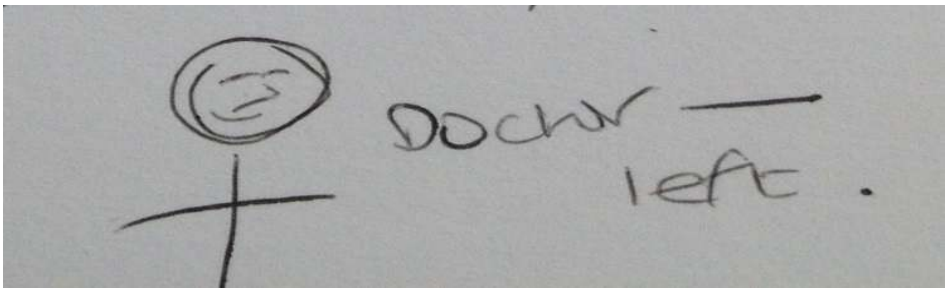

Figure 2 doctor leaving.

A male social work participant too describes being left alone by doctors once payment is confirmed:

> *And this is to depict two doctors who just leave they you know sometimes they are eligible for a payment and off they go so you're kind of left on your own*. *(Social Worker 4)*

The excerpt from his drawing also depicts the doctors in formal attire, perhaps underpinning for this AMHP the doctors' occupational superiority:

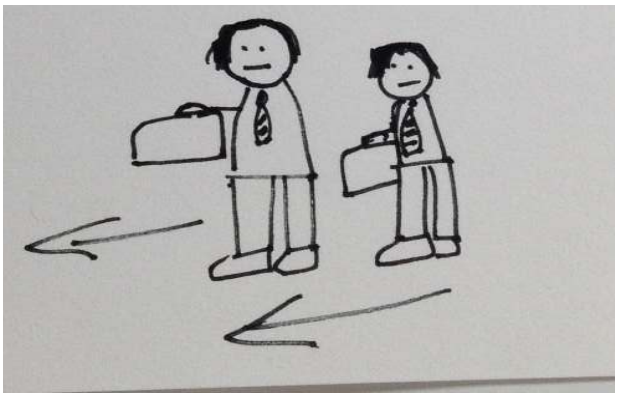

Figure 3 doctors leaving. (Matthews, 2013, p.13.)

This same participant also expresses his dissatisfaction. In his experience most doctors abandon AMHP colleagues in this way, behaviour he perceives as lacking understanding or compassion:

> *Erm and, and you know most doctors actually with the exception of one that I can think of really have very little empathy or understanding of what's going on for you. (Social Worker 04)*

The flippant manner in which the abandonment takes place is also reported:

> *They just go, "oh see you later goodbye." (Social Worker 04)*

A second male social worker also refers to doctors abandoning the process in a similarly flippant manner:

> *Well, I think being a coordinator in a way and I think you know doctors have usually buggered off at that point. (Social Worker 02)*

The issue of the doctor leaving once payment had been authorised repeats. In the dialogue between a male nurse and the interviewer this participant, whilst trying to justify the doctor's behaviour, also points out that the person being assessed might have benefitted if the doctor had remained:

> *One of them wanted his payment for signing [the medical recommendations]. In all honesty erm the consultant was in and out. To be fair, he knew her, he made the decision that she needed to be in hospital erm but he probably could have given her a little bit more time than he did.*
>
> ***Interviewer:** And did you feel that you were left with the situation then?*

Participant: *Yeah, as always.* *(Nurse 02)*

So far, AMHP participants describe and also illustrate through their drawings their perception of being abandoned by doctors. However, the data also show AMHPs perception of doctors as abandoning them even before the assessment begins.

Despite one female nurse speaking positively about the good relationship she ordinarily has with doctors in her team, the assessment she discusses does not go ahead as originally planned. The doctor, in effect sabotages the assessment for reasons, according to this AMHP that are personal to this doctor; "he preferred to go home":

> *Because it was four o'clock, it was four o'clock. Like I say our consultants here are brilliant I've known them go out at five to five. They are not God they are not angels but they are very conscientious and very, very supportive. So I've known them go out at five o'clock to help an AMHP in the community not me ….because they don't want them out there they want everything sorted as quick as possible. To get the best outcome, but he preferred to go home. (Nurse 05)*

Interestingly, the participant justifies this behaviour, otherwise viewing this colleague as "conscientious" and "supportive". Nonetheless, having to rearrange left her with an underlying sense of dissatisfaction.

Her description of a different assessment had the same initial response; the process halts because the doctor could not attend. Whilst it is not clear on this occasion as to the reason the participant still perceives abandonment:

> *initially it went wrong because I had arranged it all erm I'd arranged for the consultant to come out, not our consultant, a consultant from the community mental health team, spoke to the family got the police there because this service user was quite aggressive erm, got everything arranged for a certain time, section 12 GP had agreed to come and then the consultant turned around and said he couldn't come. (Nurse 05)*

Therefore, the process had to start again, the result of which was a delayed start time for the participant, extending her working day quite significantly and further dissatisfaction:

> *So, you are going to have to rearrange the whole process again later on in the evening. So I'd been in work from half seven [that morning] the assessment was arranged for four o'clock, I'd got a bed located everything and, then I had to go out and sort it all out again. (Nurse 05)*

However, she again justifies the behaviour, this time in the eventual and, in her opinion successful outcome. The process, as she reports, all went smoothly including the location of a local bed, a seemingly better outcome:

> *So, I was still here at nine o'clock at night but, having said that when I did the second assessment erm I got the bed more locally because somebody had gone off the ward, so I got a local bed I got the consultant and GP out within an hour of ringing them*

both and, as I got there GP, consultant turned up, police came at the same time. It doesn't normally happen like that. (Nurse 05)

For the most part AMHPs, although they express dissatisfaction at the behaviour of doctors do not through these data act on this. They instead seem able to justify it, or perhaps roll over?

On the other hand, some instances by nurse AMHPs are shown in the data providing embryonic evidence of blocking abandonment and shift. For instance, one female nurse describes an assessment that had taken place in a police cell. Here, the participant was in role as an AMHP and not, as would be otherwise the case, a nurse in a community mental health team. Others present include the doctor from the same community mental health team and a second doctor approved under the Mental Health Act 1983 to undertake such assessments, a so-called Section 12:

I was in the [police] cells seeing somebody at the police station last Friday with my consultant from the team… and a section 12 doctor, although I was working as an AMHP not as [a member of the community mental health team]. (Nurse 02)

The person being assessed was deemed potentially violent and, because of this, the doctors had ensured safety by being positioned near exit routes and panic alarms. The assessment is conducted, during which the person being assessed shows signs of aggression towards the participant:

And this guy was quite highly aroused and the police doctor has asked for a police officer to be in with us. He'd taken care to ensure that the seats were in a certain way

that we were near the exit and that we could touch alarms if we needed to. And we did the assessment and we looked at alternatives and we thought that we could probably manage him in the community. But, he was still quite highly aroused and he'd been quite aggressive to me when I had challenged some of the things that he's been saying. (Nurse 02)

Ultimately, both parties decide that formal detention is not needed. However, despite the careful preparations that had been made to ensure safety during the assessment, the doctors left the participant in the same, potentially violent, situation. The participant shows her disbelief at this behaviour:

After we went back to his cell and we talked about the outcome and we were all in agreement that he could go home with support erm and the consultant said to me, 'right so I'll leave you to let him know then….ok then, see you later' and I thought, thanks for that. Do you know what I mean - you've just gone to all that, all those lengths to preserve yourself and to make sure that you're safe and now it's right, it's Friday, it's ten past five, I'm out of here. (Nurse 02)

As if to add to the sense of being abandoned, the participant goes on to describe the doctor's attempts to also shift the required administrative tasks:

And then he did also say can you document everything you know on our record, our electronic record system. (Nurse 02)

But, she refuses. The participant in effect blocks what she perceives as the doctor's abandonment and she has in a small way, blocked an attempted shift of work by the doctor:

I said, "no sorry no that's, you need to do that I'm the AMHP here you need to do that. I've got my action form here to complete. You need to go and do that." And he had his tail between his legs a bit. (Nurse 02)

Similarly, another female nurse participant reports stalling an assessment despite what she perceives as an order from a doctor to do so:

This is how she is presenting saying this and she's saying that she's really ill and I think she's psychotic. She needs to be brought into hospital and I want you to do a Mental Health Act Assessment right now. (Nurse 05)

But she blocks this, albeit subtly:

I say oh, ok well, you know, let me just see what I can do and I'll get back to you. *(Nurse 05)*

Her underlying frustration is however clear in her drawing in which she depicts the pressure of time and of being subject to the doctors, placing herself underneath them with beads of sweat and use of wording to reinforce this:

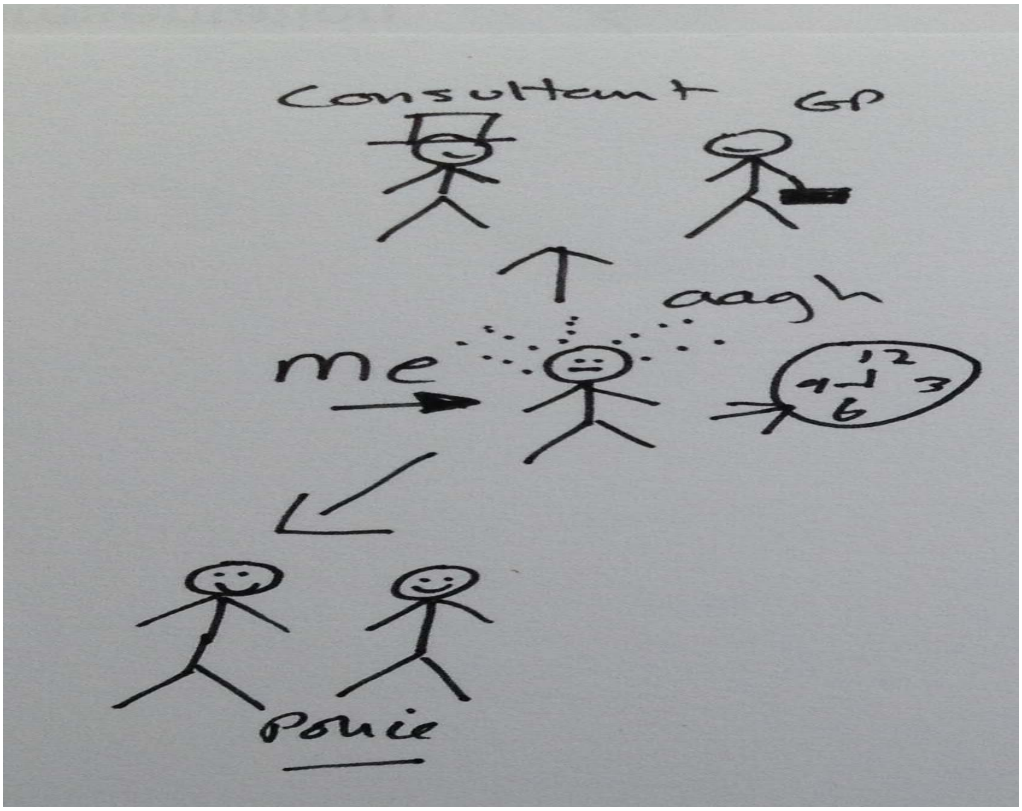

Figure 4. Frustration

These data show that from the perspective of nurse AMHPs a doctor is attempting to shift work to a seemingly lower occupation. Both nurses appear buoyed by their own altered and possibly perceived higher status as an AMHP. However, these reported attempts at blocking are few. Instead the data show that AMHPs perceive shift achieved by doctors. When it comes to another aspect of the assessment process, the medical responsibility of obtaining a bed is shifted to AMHPs. As one female nurse states, doctors shift the responsibility of getting a hospital bed through "the art of delegation":

Interviewer

So I thought it was the consultant's duty to get the bed

Respondent

No, well they delegate. They delegate to us, the art of delegation

(Nurse 05)

And so shift, the second aspect of dirty work is accomplished.

Discussion

The application of the sociological theory of dirty work to understand behaviour in psychiatric occupations is not new. However, this article explores for the first time an aspect of dirty work as it occurs during Mental Health Act Assessments, shift. To begin, participants discuss their perception of the doctor's role as abandonment or "role over" as it is being termed and is commonly characterised and expected as such. According to the Code of Practice for the Mental Health Act 1983, it is the responsibility of AMHPs and not the doctor to ensure that the assessment is completed (Department of Health, 2015). It could therefore be argued that doctors leaving assessments once the medical recommendation is complete is acceptable professional behaviour. However, it can also be suggested that absenting themselves is a narrow perception of a doctor's role in this context. This is underpinned by the dissatisfaction expressed in reflection by AMHPs, albeit not acted upon in these data. In a play on one participant's words AMHPs could be said to roll over. To use the constructs of dirty work in a different way, the behaviour encountered is dirty but through lack of overt challenge legitimises it. The management of this contradiction provides valuable insight into the behaviour of AMHPs, including social workers during Mental Health Act Assessments.

But, according to the same Mental Health Act Code of Practice, the responsibility for securing a hospital bed is that of a doctor (Department of Health, 2015, para. 14.77). Despite this, such responsibility is shown in this study to be shifted by doctors. Other, more subtle aspects of shift are evidenced, and include the attempt by doctors to handover menial tasks. To some extent AMHPs sabotage this shift; one nurse refuses to complete the administrative forms required despite being asked to do so by the doctor, presumably, as their inferior. Both the doctor and the nurse perceive this activity as menial, or dirty, but on this occasion the nurse refuses. The profession of nurses, that might otherwise be of lesser professional standing is shown to be stopping the shifting of the dirt. This act of resistance of itself becomes clean and interestingly mirrors the metaphor of coming clean, or its meaning telling the truth. This blocking might also be evidence that an altered and arguably higher status affords a different behaviour on the part of nurses but is as yet fully realised.

That this behaviour is being blocked, primarily in this study by nurse AMHPs, is of interest in the context of this article since it challenges the previous notion that AMHP work is best executed by social workers exclusively and thereby starts to introduce new ways of working, regardless of profession. A factor often put forward as a fundamental flaw in the opening of the AMHP role to professions such as nurses and occupational therapists is the possible negative impact of hierarchical deference. Doubters argue that nurses will defer to, rather than challenge, a doctor (Haynes, 1990, Quirk *et al*., 2000, Walton, 2000). Albeit relatively minor, such instances of blocking could represent a subtle change in AMHP practice and might ultimately be a precursor for others, including social workers as AMHPs. It also begins to challenge traditional nurse-doctor behaviours.

Other examples of abandonment by doctors occur in some instances even before the assessment has started but, in this study, is reported by nurse AMHPs only and is also justified by them, either by pointing out that doctors are ordinarily supportive colleagues or by suggesting the work rearranged because of being abandoned ultimately produces a better outcome. What this could show is that nurses, hitherto an occupation of lower standing to doctors, are subconsciously acting out of deference. On the other hand, it could also mean that nurse AMHPs are perceiving their work as morally determined, or clean and are able to justify the morally contentious behaviours of others. Again, it is suggested, that this is a key aspect of the occupational behaviour of AMHPs, including social workers, during Mental Health Act Assessments. There is also potential that there are gendered aspects of shift between the depiction by participants of doctors as male and the recipients of shift in the reflections of female nurses. Other aspects of identity and structural oppressions are likely to affect interactions at MHA assessments and create 'alternative' structures of power within assessment contexts. Both aspects warrant future investigation.

The abandonment experienced by AMHPs in the Mental Health Act Assessment process is accepted by AMHPs or at least is not challenged outwardly. In terms of the theory of dirty work this might be the AMHP exaggerating the importance of the dirty aspects of their role to legitimise it, in much the same way seen in earlier studies (Emerson and Pollner, 1976, Brown 1989, Morriss 2015). It may also show that the reconfigured AMHP role encapsulates a change in traditional psychiatric role relationships. What is clear is that it is not just the work that is morally contentious but also the behaviour that is perceived as such and, whilst

possibly driven by status it constitutes a new understanding of dirty work whereby shift is justified not by those doing it but by those who are subject to it, including social workers.

There are some limitations in using drawing to elicit data; some people might be too embarrassed to draw, thereby impacting on the willingness of respondents to partake. The ones that do engage may therefore be atypical. A further limitation of drawing as a research method is that participants may also focus on producing their best drawing rather than representing their actual experience. As the drawings were used to evoke and illustrate and were not for analysis as such, asking participants to talk about their drawing lessened this possibility. Nurses and occupational therapists may be distinct among their professional peers for taking on the role of the AMHP and are a small proportion of the workforce. Similarly, therefore, the findings may be based on atypical workers.

Furthermore, this study uses data gathered from AMHPs alone. Neither doctors nor people subject to the assessment are participants whose perceptions may differ. Last, the number of participants is small, and this might suggest that the findings must be interpreted cautiously. However, qualitative researchers seek to build a convincing analytical narrative based on 'richness, complexity and detail' rather than on statistical logic (Mason in Baker and Edwards, 2012 p. 5). In turn a sample is driven by matters such as epistemology, methodology and practicality. Methodologically, one important influence for IPA is a commitment to idiography or focus on participants in the context of the studied phenomenon. This study therefore is not setting out to make generalised claims but to

provide an in-depth understanding which may, or may not, resonate with others in the same situation here the experience of assessment by AMHPs, including social workers.

Conclusion

Drawing on data taken from a study exploring the role and experiences of AMHPs, a mutli-professional role nonetheless still predominantly undertaken by social workers, this article discusses the behaviour of two of the occupations involved in Mental Health Act Assessments, doctors and AMHPs and does so from the perspective of the latter. Provided through the lens of the AMHP and of the sociological theory dirty work it discusses shift, an aspect of dirty work not yet explored in the context of psychiatric occupations specifically in Mental Health Act Assessments. “Role over” as participants describe it, or abandonment as this is interpreted, is shown, along with some, albeit partial, blocking of it and of shift. However, the data show that the latter is accomplished by doctors particularly though the transfer of the responsibility of securing a bed and that this is also justified by AMHPs. Such ‘roll over’ behaviour reveals occupational behaviour by AMHPs that is contradictory and has ambiguity after Hughes (1971). It also has important implications for the understanding of the relationship between AMHPs and doctors during Mental Health Act Assessments for which the reconfigured role may be a precursor since it suggests a narrow understanding by doctors and places AMHPs, predominantly social workers, under unnecessary pressure (imagined and real) and may result in a poor experience for the person being assessed, all of which warrants re-examination and, in the light of the independent review we suggest deserves further consideration.

References

ADASS (2018). *National Findings – AMHPs. Mental Health Act Assessments and the Mental Health Social Care workforce*, London, Association of Directors of Adult Social Servcies.

Baker, S. and Edwards, R. (2012) *How many qualitative interviews is enough? Expert voices and early career reflections on sampling cases in qualitatuive research.* London, National Centre for Research Methods.

Bowers, L. Clarke, N. and Callaghan, P. (2003). Multidisciplinary reflections on assessment for compulsory admission: The views of Approved Social Workers, General Practitioners, Ambulance Crews, Police, Community Psychiatric Nurses and Psychiatrists, *British Journal of Social Work,* Vol. 33 pp. 961-968.

Bressington, D.T., Wells, H. and Graham, M. (2011). A concept mapping exploration of social workers' and mental health nurses' understanding of the role of the Approved mental Health Professional, *Nurse Education Today*, Vol 31, pp. 564-570.

Brown, P. (1989). Psychiatric dirty work revisisted, *Journal of Contemporary ethnography,* Vol. 18(2), pp. 182-201.

Buckland, R. (2016) The decision by Approved Mental Health Prfoessionals to use compulsoty powers under the Mental Health Act 1983: a Foucauldian discourse analysis *British Journal of Social Work* Vol 4 (1), pp. 46-62.

Campbell, J. (2010). Deciding to detain: The use of compulsory mental health law by UK social workers, British Journal of Social Work, Vol. 40, pp. 328-334.Checkland, P. (1980). *Systems thinking, systems practice,* London: Wiley.

Christian, L. (1985). *Approved Social Work? Ten mental health case studies - before and after the '83 Act*, Social Work Monographs, University of East Anglia.

Davidson, G. and Campbell, J. (2010). An audit of assessment and reporting by Approved Social Workers (ASWs), *British Journal of Social Work*, Vol .40, pp. 1609-1672.

Department of Health 1999 *Review of the Mental Health Act 1983: Report of the expert committeee,* London: Department of Health.

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

Department of Health and Social Care (2017). *Terms of reference: independent review of the Mental Health Act 1983*. London, Department of Health and Social Care.

Evans, S., Huxley, P., Gately, C., Webber, M., Mears, A., Pajak. S., Medina, J., Kendall, T. and Katona, C. (2006). Mental health burnout and job satisfaction among mental health social workers in England and Wales, *The British Journal of Psychiatry*, Vol. 188, pp. 75-80.

Evans, S., Huxley, P., Webber, M., Katona, C., Gately, C., Mears, A., Medina, A., Pajak, S. and Kendall, T. (2005). The impact of 'statutory duties' on mental health social workers in the UK, *Health and Social Care in the Community*, Vol 13(2), pp. 145-154.

Emerson, R. and Pollner, M. (1976). Dirty work designations: their features and consequences in a psychiatric setting, *Social Problems*, Vol. 23(3), pp. 243-254.

Fakhoury, W.K.H. and Wright, D. (2004). A national survey of Approved Social Workers in the UK: Information, communication and training needs, British Journal of Social Work, Vol 34, pp. 663-675.Guillemin, M. (2004). Understanding illness: Using drawings as a research method, *Qualitative Health Research,* Vol 14, pp. 272-289.

Fisher, M. Newton, C. and Sainsbury, E. (1984). *Mental health social work observed*, Londo,: George, Allen and Unwin.

General Social Care Council (2012). *GSCC targeted inspections of Approved Mental Health Professionals (AMHPs) courses in England, 2012-2011*, London, General Social Care Council.

Gregor, C. (2010). Unconscious aspects of statutory mental health work: Emotional labour and the Approved Mental Health Professional, *Journal of Social Work Practice* Vol 24, pp. 429-423.

Hatfield, B. (2008). Powers to detain under mental health legislation in England and the role of the Approved Social Worker: An anlysis of patterns and trends under the 1983 Mental Health Act in six local authorities, *British Journal of Social Work*, Vol. 38, pp. 1553-1571.

Haynes, R. (1990). After 1983: Approved Social Workers' perceptions of their changing role in emergency psychiatric assessments, *Practice: Social Work in Action*, Vol. 4(3), pp. 184-198.

Health and Care Professions Council (2013). *Approval criteria for Approved Mental Health Professional (AMHP) programmes,* London, Health and Care Professions Council.

Her Majesty's Government (2008). *The Mental Health (Approved Mental Health Professionals) (Approval) (England) Recommendations,* London, Her Majesty's Government.

Hudson, J. and Webber, M. (2012). The National AMHP survey 2012 final report. Stress and the statutory role: is there a difference between different professional groups, London.

Hughes, E. (1971). *The Sociological Eye: Selected papers,* Chicago, Aldine Atherton.

Huxley, P. Evans, S., Webber, M. and Gately, C. (2005). Staff shortages in the mental health workforce: the case of the disappearing Approved Social Worker, *Health and Social Care in the Community*, Vol 13(6), pp. 504-513.

Kearney, K.S. and Hyle, A.E. (2004). Drawing out emotions: the use of participant-produced drawings in qualitative inquiry, *Qualitative Research*, Vol 4, pp. 361-382.

Larkin, M., Watts, S. and Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis, *Qualitative Research in Psychology,* Vol 3, pp. 102-120.

Mental Health Act (1983) as amended by Mental Health Act (2007). London, HMSO.

Matthews, S (2013) Drawing as a research method: exploring the role and experiences of Approved Mental Health Professionals Sage Research Methods Online ISBN 9781446373050

Morriss, L. (2014). *Accomplishing social work identity in interprofessional mental health teams following the implementation of the Mental Health Act, 2007,* United Kingdo,: University of Salford

Morriss, L. (2015). AMHP work: dirty or prestigious? Dirty work designations and the Approved Mental Health Professional, *British Journal of Social Work,* Vol. 46(3), 703-718.

Myers, F. (1999). Social Workers as Mental Health Officers: Different Hats. Different Roles? in *Mental Health and Social Work* in Ulas, M. and Connor, A. (eds), London: Jessica Kingsley

Parker, J. (2010). Approved Social Worker to Approved Mental Health Professional: evaluating the impact of changes within education, *The Journal of Mental Health Training, Education and Practice*, Vol 5(2), pp. 19 -26.

Prior, P. (1992). The Approved Social Worker: Reflections on origin *British Journal of Social Work,* Vol. 22, pp. 105-109.

Quirk, A. (2008). *Obstacles to shared decision-making in psychiatric practice: Findings from three observational studies,* United Kingdom, Brunel University

Quirk, A., Lelliott, P., Audini. B. and Buston, K. (2000). *Performing the Act: A qualitative study of the process of mental health act assessment,* London, Department of Health.

Reid, K., Flowers, P. and Larkin, M. (2005). Exploring Lived Experience. *The Psychologist,* Vol 18(1), pp. 20-23.

Sheppard, M. (1990). *Mental Health: The role of the Approved Social Worker*, Sheffield: Joint Unit for Social Service Research.

Shinebourne, P. (2011). The theoretical underpinning of interpretative phenomenological analysis (IPA), *Existential Analysis,* Vol 22(1), pp. 16-30.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology, *Psychology and Health* Vol 11, pp. 261-271.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative psychology, *Qualitative Research in Psychology,* Vol 1, pp. 39-54.

Smith, J.A. (2007). Hermeneutics, human sciences and health: linking theory and practice, *International Journal of Qualitative Studies on Health and Well-being,* Vol 2(1), pp. 3-11

Smith, J. A. and Osborn, M. (2003). Interpretative Phenomenological Analysis in J.A. Smith (ed.), *Qualitative Psychology: A Practical Guide to Methods*, London: Sage.

Smith, J.A., Flowers, P. and Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research,* London, Sage

Stevens, M, Martineau, S., Steils, N. and Norrie, C. (2018) *Who wants to be an Approved Mental Health Professional?* London, Social Care Workforce Research Unit, King's College, London.

Theron, L., Mitchell, C., Smith, A. and Stuart, J. (2011). *Picturing Research: Drawing as visual methodology,* Rotterdam: Sense.

Vicary, S. (2016). An Interpretative Phenomenological Analysis of the impact of professional background on role fulfilment: a study of approved mental health practice. United Kingdom, University of Manchester.

Vicary, S, Young, A and Hicks, S. (2017) A reflective journal as learning process and contribution to quality and validity in Interpretative Phenomenological Analysis Qualitative Social Work Vol 16, issue 4, pp. 550-565.

Walton, P. (2000). Reforming the Mental Health Act 1983: an Approved Social Worker perspective, *Journal of Social Welfare and Family Law,* Vol. 22(4), pp. 401- 414.

Watson, D. (2016). Becoming and Approved Mental Health Professional: an analysis of the factors that influence individuals to become Approved Mental Health Professionals *Journal of Mental Health* Vol 24(4) pp. 310-314.

Figure legend

Figure 1." role over" (Vicary et al., 2017 p. 9.)

Figure 2 doctor leaving.

Figure 3 doctors leaving. (Matthews, 2013, p.13.)

Figure 4. Frustration