Approved Mental Health Professionals: Negotiating dialogic identities as hybrid professionals

A thesis submitted to The University of Manchester for the degree of Education Doctorate in the Faculty of Humanities

2017

Caroline Leah

School of Environment, Education and Development
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The Hybrid Identities Project (HIP) investigates the professional role and identities of Approved Mental Health Professionals (AMHPs) as hybrid professionals. Hybrid professionals are professionals of mixed origin who operate within broad knowledge areas with competence developed outside of their main area of expertise. AMHPs are hybrid in several interrelated ways; in the varied professional specialisms that became generic for the AMHP role when it was extended from the previously exclusive specialist Approved Social Work role, and in the areas of expertise enacted through roles, boundary spanning and professional perspectives that encompass legal, social, therapeutic and psychiatric jurisdictions of practice. This means that AMHPs have complex and negotiated professional roles; therefore, hybridity within identities is a valid site in which to explore the types of hybridisation visible within AMHP professional roles and identities.

The methodology is a case study of professional identities located in the stories of ten AMHPs from social work, nurse and occupational therapy backgrounds. Data is generated through thirty topic-based interviews conducted in three stages over a period of two years. Each interview explores specific but interrelated areas of professional roles and identities, comprising participants’ espoused knowledge, skills and values, influences on career choices and professional hybridisation. The research is conceptualised by drawing on social and professional identity theorisations, concepts of hybridity and dialogism.

Illuminative participant data focusing on hybrid ‘perspectives in use’, hybrid roles and boundary spanning are presented from social work, nurse and occupational therapy primary professional backgrounds. These interrelated dimensions are expressions and enactments of hybrid professionals’ identities, as they reveal how participants author the world through language that is ‘borrowed’ from other professionals and how participants navigate boundaries between social, healthcare and external organisations, indicating epistemological hybridity. Boundaries are negotiated that cross-cut traditional jurisdictions of other specialist professional roles claimed, illuminated through participants’ everyday practices to reveal professional identities as hybridised across all primary professionalities within the sample.

This is followed by a detailed thematic analysis of professional hybridity that conceptualises AMHP professional identities as hybridised and dialogically negotiated. Professional identities are negotiated within the employing organisation’s culture but interplay with working relationships amongst other professionals within Mental Health Act work and with broader professional, systemic and socio-political contexts in contemporary life, creating ‘ironic dialogism’.

In investigating AMHPs as hybrid professionals negotiating dialogical identities, the HIP contributes to knowledge of AMHP multi-professional roles and identities, professional hybridity, dialogical identities and the sociology of professions. It illuminates AMHPs’ biographies as they are enacted and located in the intersubjective professional realities of everyday life, contributing sociologically to broader understanding of professional hybridity in related professional groups and an understanding of boundary spanning as a site of (re)organisation for AMHP professional identities.
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ACKNOWLEDGEMENTS

My doctoral study would not have been possible without my participants, who not only gave so generously of their time but entertained, inspired and humbled me with their stories. A huge thank you to you all and for all that you continue to do in one of the most impossible but privileged of professional roles. To my husband, you know me so well and there was always a cup of tea and a smile when I needed it most, thank you for being you. To my daughter, although you are too young to understand, I know you are proud of Mum and know that Mum ‘is doing her important work.’ I hope I will inspire you to achieve your dreams whatever they may be.

A sincere thank you to my supervisors Professor Alan Dyson, for his encouragement, pragmatism and wisdom. To Professor Helen Gunter, a huge thank you for your enthusiasm for my intellectual endeavour, encouragement, guidance and wisdom. You have been instrumental in the development of my thinking and scholarly endeavour.

I dedicate this study to those who are lost in mental distress, who need kindness, compassion and support.
THE AUTHOR

I am a social work educator at Manchester Metropolitan University where I am a Programme Lead for the Post Qualifying MA in Advanced Social Work Award. Prior to this, I taught for 7 years on the MSc in Applied Mental Health at the University of Manchester on the Approved Social Work and Approved Mental Health Professional course. I joined academia after managing a community mental health team of multi-disciplinary professionals, including social workers, nurses, occupational therapist, psychologists and psychiatrists in an integrated social care and health organisation. I have worked for over 25 years in the mental health field in numerous settings and with people experiencing chronic, acute and severe and enduring mental health issues. I also have experience as a carer. This positions me as an insider researcher. Indeed, I occupy several visible identity positions, as an academic, as a researcher, as a professional social worker, as a mother, a wife, a friend. We are who we are, and who we reveal ourselves to be, in the context of the event called our life.
Chapter One

Introduction to the HIP (AMHP)

1.0 Introduction to the study

The aim of the Hybrid Identities Project (HIP) reported in this thesis is to provide new insights and understanding of Approved Mental Health Professionals’ (AMHP) role(s) and identities as a form of professional hybridity, and is predicated on the notion that AMHPs experience and benefit from professional hybridity through dialogic interactions in their professional practices. In doing so, I am defining professional hybridity through drawing on Blomgren and Waks’ (2015, p.79) definition of hybrid professionals, who are ‘professionals who operate within broad knowledge areas, who have developed competence outside of their main area of expertise … in situations characterised by institutional complexity’. This differs from Noordegraaf’s conceptualisation of ‘hybridized professionalism’ (Noordegraaf, 2007, p.773) and such evident areas of divergence will be appraised in chapters 3 and 4.

Additionally, I will investigate if AMHPs as hybrid professionals enact multiple roles and professional hybridisation through the use of hybridised language that cross-cuts other areas of others’ professional practice and expertise through dialogism (Holquist, 2002). Although the role of Approved Social Workers (ASWs), who later became AMHPs, has been articulated in several empirical studies (e.g. Fakhoury and Wright, 2000; Quirk et al, 2000; Davidson and Campbell, 2010; Gregor, 2010; Webber and Nathan, 2010), the multi-professional roles and identities of AMHPs has so far not been empirically researched and is a research gap.
This study presents and uses a novel approach to hybridity within and for AMHP professional roles and identities. To do this the research project is structured through these research questions:

1. What is the role of the AMHP and how can AMHP professional identities be understood?
2. What is a hybrid professional and in what ways is it appropriate to conceptualise AMHPs as hybrid professionals?
3. What recommendations can be made regarding the use of hybrid professional roles and AMHP professional identities in the recruitment, training and practice development of AMHPs?

These questions are important because they address the need to map and reveal the biographies and experiences of those who take on AMHP roles and how AMHP identities are enacted, and they connect with the imperative to understand what professionalism is about, how it is understood and practised. Importantly, the study will confront the varied professional origins of AMHPs through examining the notion of hybridity, where I use a conceptual framework that draws on key concepts of hybridity (Macfarlane and O’Reilly, 2012). This includes hybridised language, named in the HIP (AMHP) as ‘perspectives in use’, where language used is drawn from a multitude of available perspectives to signify identity positioning and repositioning; hybrid roles, as discursive externalisations of nested roles beyond the professionally recognised role of ‘legal applicant’ and boundary spanning where work cross-cuts multiple organisations and intersects several disciplines. In addition to concepts of hybridity I draw on dialogism as a key concept, where the professional self responds to others in a flow of conversation, and thereby makes claims on professional identities, and social and professional identity theorisations (Goffman, 1959; Abbott, 1995; Giddens, 1991; Holquist, 2002; Jenkins, 2008; Noordegraaf, 2007, 2015; Billot, 2010; Oliver,
2015). These concepts provide an effective educational lens to investigate how professional roles and identities are enacted and understood. This was done through a case study methodology whereby professional identity was the ‘case’ and was examined through thirty narrative interviews with ten multi-professional AMHPs over a two-year period from a range of professional locations in the North of England (Mason, 2014; Yin, 2014).

My research makes an empirical and conceptual contribution to the field of AMHP research, practice and education. It builds on previous studies of social work AMHP professional identities (Leah, 2012, Leah, 2013; Morriss, 2014, 2015a, 2015b) by examining AMHP professional identities from multi-professional backgrounds. This reveals AMHPs as hybrid professionals who enact dialogical identities: a contribution that specifies a new conceptualisation of AMHP professional identities. In the next section I explain my research rationale.

1.1 Rationale

Professional context

The impetus for the HIP (AMHP) (hereafter HIP) study derives from my professional context as a programme lead/senior lecturer of post qualifying social workers and AMHPs. I was concerned to engage in research that informs the training of AMHPs, in an under-researched professional role.

In 2007, when the role changed from ASW to AMHP, I developed curricula for training the new primary professional group of nurse and occupational therapy AMHPs, where social
perspectives were embedded in the taught content. I was concerned that new professionals attending the AMHP course from nurse and occupational therapy backgrounds could destabilise and demoralise social work AMHPs and generate what Abbott (1995) refers to as ‘turf wars’, leading to an inadequate medicalised AMHP service, and this could detrimentally impact on service users and their carers (Nathan and Webber, 2010). Additionally, that ASWs expertise of the social perspective could be diluted by medical professionals training as AMHPs. These issues influenced my focus to investigate professional identities and role from multi-professional backgrounds, unlike other studies that have investigated the AMHP role and identities from social work AMHPs (Morriss, 2014, 2015a), and my interest in investigating how AMHPs can be understood as hybrid professionals. Engaging in identity work is necessary for AMHPs to enact their professionality and development relevant to professional bodies, policy makers, legal frameworks and the service they provide. Both the construction of these arenas and the enactment of the AMHP role within the mental health field are important to my study.

**Educational context**

The rationale for this study is located in my studies in the EdD Education Programme, as well as wider research and policy change issues. I begin with my research trajectory. The HIP has its antecedent in my professional doctoral studies and provides an effective educational lens for exploring how professional role and identities can be understood and theorised. The three doctoral research papers (Leah, 2011, 2012, 2013) completed so far reflect policy and professional concerns and have led in different ways to this thesis. In my first paper, I was concerned to explore the role of the Approved Social Worker, and the intersections between enacting professional roles and identities. This was a literature review that drew on social
identity theorisations and social work professional identities (Leah, 2011). I learnt that professional identity is a contested term that is used in different ways and carries different meanings. Some scholars define it in terms of fixed stable traits (e.g. Moore and Hoffman, 1988; McCowen & Hart, 1990; Weinrach, 2000; Davies, 2003), whilst others define it as enacted or fluid and subject to change (e.g. Giddens, 1991; Bauman, 2004; Reynolds, 2007; Jenkins, 2008; Billot, 2010).

My assumption is that professional identities can be interpreted as embodying inner functions and characteristics that are codified through, for example, professional regulation and are subject to organisational influences. However, identities evolve, are fluid and ‘involve a subjective interpretation of our individuality in the context of activities’ (Billot, 2010, p.3). Identities will be enacted dynamically in different ways, depending on contextual factors (Bauman, 2004, Jenkins, 2008). The interrogation of the ways professional identities could be codified led to my second research paper (Leah, 2012). In this, I investigated the codified aspects through fieldwork using a Q-sort, researching AMHP competencies to pilot this way of understanding professional identities. This led to an account of how competencies were being interpreted by participants, but my evaluation of the method was that it did not produce data that enabled nuances in professional identities to be explained, or how the context of policy and practice imperatives interact with professional identities. I identified these areas as an important issue for the research design to underpin this thesis project, and so in in my third research paper (RP3, Leah, 2013) I presented a proposal and pilot study. In the pilot study, I examined how AMHPs are located within discourses concerning professionalism, and how professionalism is increasingly discussed as being hybrid (Warrington et al, 2004; Faulconbridge and Muzio, 2012; Byrkjeflot and Kragh Jespersen, 2014; Noordegraaf, 2007; Kirkpatrick and Noordegraaf, 2015). This paper directly informed this thesis in developing a
study that investigates hybrid professionals (Noordegraaf, 2007, 2015; Oliver, 2013; Blomgren and Waks, 2015), dialogism (Holland and Lave, 2000; Holquist, 2002; Bradbury and Gunter, 2006; Beech, 2008, 2011) and professional identities (Abbott, 1995; Davies, 2003; Billot, 2010; Oliver, 2013; Morriss, 2014, 2015a; Webb, 2016). The conceptual framework derived from RP3 (Leah, 2013) emphasised the importance of adopting hybridity as a major concept for investigating AMHP professional identities and is further extended within the HIP.

**Context of the HIP**

My EdD studies and writing for the research papers were happening at a time of major change in mental health policy and practice that were influencing how the role of the AMHP was being enacted and understood. Professional roles and identities are located amongst wider professional practice and policy imperatives. During my empirical research the AMHP regulatory body has changed from the General Social Care Council to the current Health Care and Professional Council, with a new regulator, Social Work England, being proposed for 2018. National workforce planning reveals AMHP numbers are shrinking at a time of increased demand, with detentions under the Mental Health Act increasing by 9% in 2015-16 (NHS Digital Report, 2016). The number of service users admitted to out of area (often private) beds (30% of patients) has risen significantly, resulting in widespread criticism of the government for its failure to carry out any national workforce planning or to evaluate the impact this has on service users and their families receiving inadequate service provision (BASW, 2016), or to examine the impact of austerity that has resulted in the lack of hospital beds and community resources, a key provision for AMHPs when considering less restrictive care and treatment options to detention under the Mental Health Act (hereafter ‘the Act’) (Department of Health, 2007) (CQC, 2016). This research project has taken place within this contentious policy and
practice context, which has made these concerns more urgent, and is relevant for investigating AMHPs as hybrid professionals and the ways this is appropriate for AMHPs. My research aims and questions are located within these concerns. These dynamic contexts influence how AMHPs practise and how their professional identities are enacted. Given this new socio-political landscape, identities are key and the ways they are influenced, mediated and integrated within professional identities is reflected in my methodology.

1.2 Overall Contribution

The overall contribution is to provide empirical data in the form of narrative interviews with AMHPs, and to read this data through a new conceptualisation of the hybrid professional. Therefore, the field will have the opportunity to gain new insights into the espoused professional practices from AMHPs and to consider the gains made through hybridity and dialogism as appropriate conceptualisations. An empirical understanding of AMHPs’ role and professional identities as they are enacted is illuminated, contributing to studies of hybrid professionals, hybrid professionalism, professionalism, professional identities, dialogic identities and dialogism. The HIP is worthwhile as it investigates an area that has so far not been researched. It contributes to mapping and revealing AMHP roles and identities so that the profession, policy makers and the Chief Social Worker for England may consider if the findings enable a better understanding of the ways to improve the training and education of AMHPs and the organisational delivery of the AMHP service.
1.3 Thesis Structure

The chapter that follows is a contextual chapter where I locate key government policies that could influence how professional roles and identities are enacted. This inevitably presents problems, paradoxes and ironies in role enactment and identities that will be illuminated through my field work, in chapters 6 and 7. Chapter 2 explains who AMHPs are, their statutory duties, role and responsibilities from legal, empirical and theoretical positions. Chapter 3 discusses professional identities, addresses ideas of professionals, professionalism, professionality and professional socialisation (Evans, 2013; Evetts, 2013); where I provide an account of the identity theorisations important to this study, through drawing on key concepts situated within social identity theorisations (Goffman, 1959; Stets and Burke, 2000; Jenkins, 2008) and professional identities (Briggs, 2007; Billot, 2010; Webb, 2016). Chapter 4 draws on Holquist’s theory of dialogism (Holquist, 2002), and presents hybridity as a lens through which to investigate AMHP professional identities. I present key ideas on hybridity, hybrid roles and hybrid identities, through which AMHP professional identities can be illuminated, summarising with an argument for extending the current concept of hybridity to include hybrid ‘perspectives in use’, hybrid roles and boundary spanning as sites where AMHPs’ roles and professional identities are visible (Noordegraaf & Meulen, 2008; Noordegraaf, 2015). This is followed by chapter 5, which details my research design, including an explanation of case study, fieldwork, recruitment, type of interviews, data analysis, ethics, positionality and relatability. Chapters 6 and 7 present the significant findings of the HIP, with chapter 6 presenting case description through selected participants as embedded units within the larger case of professional identities organised by types of hybrid professional dimensionalities and structured through accounts of hybrid roles, hybrid ‘perspectives in use’ and boundary spanning, before leading onto chapter 7 with a thematic discussion of
'perspectives in use’, hybrid roles, boundary spanning, dialogical identities and ironic dialogism and the interrelationships from across the dataset.

Chapter 8 is my conclusion, where I show the overall contribution of the HIP, including the significance of the research questions for illuminating AMHP roles and professional identities, the implications for professional practice, research and the theoretical development of hybridity as a lens for investigating professional identities. I recommend further areas of research, identify my overall contribution to knowledge and end with a reflexive discussion.
Chapter Two

The Reform of the ASW role

2.0 Introduction

The structure of this chapter is as follows. Firstly, I discuss the important issues that impact on contemporary AMHP practice, illuminating the legally defined elements of the role within a legal and policy context that led to the contested change from a singular professional ASW role to multi-professional AMHP role. Secondly, I examine what this contextual history means for AMHP practice, through examining legal, theoretical and empirical accounts of how the ASW and AMHP role is understood, shaped and practised within the field of mental health. Thirdly, I appraise the historical context for why changes were implemented, locating current scholarly knowledge on the role of the AMHP. This is important for the HIP as these contextual changes in policy, law and research provide knowledge of who AMHPs are, how they have been understood and, importantly, provide the foundation for understanding AMHPs as potential hybrid professionals within the HIP.

2.1 The legal role of the AMHP

The Mental Health Act (MHA, 1983, hereafter, the Act) (Department of Health, 1983, 2007) is the legal framework providing authority to admit, detain and treat patients in mental health hospitals who have a mental disorder, who are placing their own health or safety, or other people’s safety at risk (MHA s.1(2), Department of Health, 2007). The statutory role of the
AMHP is enshrined in the Act and its related code of practice and regulations (MHA, 1983; 2007; Code of Practice Chapter 14, 2015). AMHPs have overall responsibility to arrange and coordinate assessments for individuals in acute mental health crisis involving several tasks, e.g. arranging for doctors to assess, advising police to attend where there are risks to other people (including the AMHP), and arranging transport (usually an ambulance) to take the person to hospital. Assessments are undertaken 365 days of the year, in a variety of locations, over a 24-hour period. These professionals communicate with a wide variety of people within a spectrum of mental disorder, such as those with psychotic illnesses, learning disabilities or dementia during MHA assessment, and work on behalf of local authorities undertaking statutory functions and duties under the Act (Department of Health, 1983, 2007). To be eligible for local authority approval, specialist post graduate training on a course approved by the Health and Social Care Professions Council (HCPC) is required.

Key duties involve making an application for compulsory detention in hospital, taking the individual’s social circumstances into consideration, consulting with a legally defined nearest relative (s.26 MHA), and with other people involved with the individual’s care, including a care coordinator if they are supported on the Care Programme Approach (CPA, 2008), other involved professionals, e.g. psychiatrists, section 12 doctors, general practitioners, community mental health social workers and nurses, people working for statutory, voluntary or independent services, and other service providers who do not specialise in mental health services but have contact with the service users, e.g. housing.

AMHPs therefore lead interagency and inter-professional working arrangements and this is codified in the professional competency framework (HCPC, 2013). Additional competencies
require AMHPs to apply an understanding of ‘complex legal and policy frameworks’ to individual presentations of ‘mental disorder’, a legal term used within the Act to describe mental illness predominantly, alongside the ability to work in partnership with individuals, families and carers when assessing, communicating and making decisions to detain.

AMHPs make applications for compulsory admission to hospital when they have interviewed ‘the patient’ in a ‘suitable manner’; and are satisfied that in ‘all circumstances of the case’ hospital admission is the most appropriate way of providing the care and medical treatment the individual needs (MHA, 1983, 2007). In doing so, AMHPs must consider other appropriate legal frameworks that could restrict an individual’s liberties, to ensure that any restrictions are both proportionate and legal (HRA, 1998). This involves AMHPs agreeing the individual under assessment shows evidence of a mental disorder (defined as ‘any disorder or disability of the mind’ (MHA, 2007, s.1 (2)) which is of a nature (chronicity of illness) or degree (current manifestation of the illness) to warrant admission in hospital (s.2 (a) MHA, 2007), and it is in the interests of the person’s health or safety, or with a view to the protection of others (s.2 (b) MHA, 2007). AMHPs must make a judgment informed by the presentation of risk that there are no ‘less restrictive alternatives’ to detention in hospital, involving a consideration of medical recommendations given by specialist doctors. AMHPs therefore have:

Overall responsibility for coordinating the process of assessment and they need to provide professional judgments and reach decisions independently of the doctors (Code of Practice MHA, 2007 (2008), cited in Jones, p.773).

AMHPs are independent professionals with functions of a public nature bound by duties of legal frameworks, including those applying to children. Although AMHPs act on behalf on the Local Authority, they cannot be instructed by the Local Authority or anyone else. They must exercise professional judgment, providing an ‘independent decision’ to counterbalance
the medical opinion of doctors, informed by social perspectives of mental illness, considering the least restrictive option and the ‘maximising independence’ guiding principle (s.13(2) MHA, 2007). Before making an application for detention, AMHPs plan for the immediate care of any pets, dependent children or relatives who rely on them for care (Code of Practice MHA (2015), cited in Jones, 2016), secure property and protect its contents, a duty held under the Care Act, 2014 (Department of Health, 2014).

If satisfied that criteria for detention in hospital are met and that alternatives to detention are unsuitable, AMHPs complete an application (s.13, MHA, 1983, 2007). A completed application along with the required medical recommendations provides the legal authority to detain the patient (s.11 MHA, 1983, 2007). This effectively means that AMHPs are in a legal assessment role when an individual experiencing mental health problems requires admission to hospital but lacks the capacity or insight to be admitted on an informal basis. Once an application is made, AMHPs have a duty to convey the person to hospital and provide an outline social circumstances report to the hospital, giving reasons for the application and details of any practical issues or matter requiring attention (Code of Practice MHA (2015), cited in Jones, 2016).

Alternatively, AMHPs can make other ‘less restrictive’ arrangements for the individual to be treated and cared for in the community. This involves working with other professionals, such as psychiatrists, general practitioners (GPs) and community psychiatric nurses (CPNs), and teams such as crisis resolution or home treatment teams (CRHT) to provide the individual with intensive medical home based support and/or community support (for a summary of additional duties see Appendix R).
The powers of a police constable are given to AMHPs under section 135 to search and remove a patient to a place of safety (s.135, MHA, 1983, 2007). Assessment may also take place at a designated ‘place of safety’ (s.136, MHA, 1983, 2007), usually a hospital site or police station. An AMHP has a duty to interview a patient arrested by the police on a section 136, or to discharge them from a section 136 once it is established that no mental disorder exists or that alternative care and treatment can be provided following AMHP assessment.

The AMHP role is a legal role and decisions made under the Mental Health Act often interface with duties under the other legal frameworks, e.g. Mental Capacity Act (Department of Health, 2005) and the Deprivation of Liberty Safeguards (Department of Health, 2008). These interface issues have been the subject of case law decisions and impact on AMHP duties and their role. Individual capacity, consent and objection to treatment intersect in a complex and dynamic way and it is the AMHP’s role to judiciously evidence their decision making by drawing on relevant legal frameworks, whilst having regard for case law decisions (Mathews et al, 2012; Allen, 2014). The AMHP role is codified by professional values, including a strong anti-discriminatory practice element to ‘redress discrimination and inequality in all its forms in relation to AMHP practice’ and to ‘promote rights, dignity and self-determination’ and, significantly, to ‘assert a social perspective’ within AMHP practice as a counterbalance to doctors’ medical perspectives (Mental Health Act (A.M.H.P) Regulations, 2008).

The AMHP therefore has a fixed legal role and a coherent jurisdiction to make an application for detention or not (MHA, 1983, 2007). S/he has intellectual property of this role, enshrined in the Act’s regulations, code of practice and its guiding principles; however, the process of enacting these duties is inevitably complicated and involves AMHPs working with a
multitude of professionals and organisations. This work takes place in areas of inter-
professional action and leads to inter-professional conflicts (Campbell and Davidson, 2012; 

The role and duties of the AMHP are unique in that they straddle both legal duties and 
are required to act as a counterbalance to medical perspectives, ensuring that social 
models are considered and the individual is assessed holistically, taking account of the 
whole circumstances of each and every case... (TCSW, 2014, p.8).

AMHP regulations explicitly detail the AMHP role to negotiate and manage compulsory 
admission to hospital (Mental Health Act (A.M.H.P) Regulations, 2008) by collaborating 
with a wide range of individuals, and organisations that straddle other professional 
jurisdictions of practice, such as a medical role. This is evidenced by the following 
competencies: ‘apply in practice a range of models of mental disorder, including the 
contribution of social, physical and developmental factors’ (3a), understand the ‘implications 
of a range of treatment and interventions for patients’ (3d), and ‘presenting a case at a legal 
hearing (5e) (Mental Health Act (A.M.H.P) Regulations, 2008). The competencies 
operationalise the AMHP role as a professional who straddles other professionals’ 
boundaries, evidenced by understanding treatments and interventions, the traditional preserve 
of medical professionals, a legal jurisdiction of presenting evidence at legal hearings, and the 
models (or perspectives) applied by AMHPs to understand individual presentations of mental 
ilness that are codified as pluralistic, incorporating social, physical and developmental 
factors. AMHPs’ duties and the competency framework therefore suggest that AMHPs could 
be hybrid professionals, a concept that is considered in detail in chapter 4.

This section has summarised the legal aspects of the AMHP role, suggesting the role is 
codified through its competency framework as a hybrid professional role. In the following 
section the complex processes that reshaped the ASW role into the AMHP role is appraised.
2.2 The legal and policy context

In the late 1990s, the ASW role was criticised for failing to protect service users’ rights through neglecting to invoke social perspectives to counteract dominant psychiatric discourses during MHAA. As this was its strongest jurisdictional claim, questions were raised regarding its ongoing effectiveness to provide an effective counter challenge to doctors’ medical recommendations (Mankelow et al, 2002; Rapaport, 2006; Nathan and Webber, 2010; Gregor, 2012). Consequently, Professor Louis Appleby (a prominent international psychiatrist and mental health tsar under the Labour Government in the early 2000s) argued for a widening of the range of professionals who could undertake the ASW role to include other mental health professionals, a context located within a government-driven agenda of professional integration and the perceived shortfall in the number of mental health social workers eligible to train. Additionally, the existing workforce had a high number of ASWs who were due to retire (the population of ASWs halved between 1992 and 2002) and local authorities had not planned for the shortfall (Mental Health Act Commission, 2005; Huxley et al, 2005). After much debate, the resultant Mental Health Bill (2006) proposed that professionals with the right skills, competences and experience could undertake new roles, instead of restricting roles automatically to a singular professional group, and supported a competence-based approach to professional practice. The bill proposed replacing the Approved Social Worker role, discussing the:

Potential to increase the numbers of AMHPs, thus reducing pressure on the existing ASW workforce; greater access to AMHPs in rural settings; career opportunities for non-social-work professionals, a greater emphasis on social perspectives for NHS staff; and solutions to workforce problems regarding recruitment, retention and age. The introduction of such flexibility should provide a catalyst for change in terms of workforce planning and a more appropriate and affordable skill mix (NIMHE, 2007, p.34).

These proposals were contested during the Mental Health Draft Bill by numerous social work organisations and service user pressure groups (Foster, 2006), with two key themes
emerging: the power of health organisations to impose a health driven agenda of
multidisciplinary and inter-professional working within a bureaucratic neoliberal landscape
(HM Government, 2009; Nathan and Webber, 2010), and the demise of local authorities as a
locus of control and support for existing ASWs, who remained accountable to the Local
Authority but whom Mental Health Trusts increasingly employed.

In 1999, the government launched a major programme of modernisation in mental health
services through a National Service Framework (Department of Health, 1999). Since then,
through numerous iterations of policy and legislative change, there has been a focus on generic
roles and the integration of health and social care structures (National Service Framework for
Mental Health, 1999; Care Programme Approach, 2008); namely, through service level
agreements under section 75 of the National Health Service Act (NHS Service Act, 2006). This
facilitates the secondment of social care staff to NHS bodies and the transfer of health-related
functions of local authorities to NHS bodies, so although AMHPs are accountable to local
authorities they sit in integrated teams in integrated services, dislocated from local authority
structures.

This promotion of inter-professional working, a legacy of the previous Labour Government,
populated the public sector with professionals from diverse professions and sectors to become
adept at operating within the discursive practices of colleagues from differing professional
backgrounds (Reynolds, 2007). The reconfiguration of professional practice witnessed across
a range of health and social care sectors, a discussion outside the confines of this study,
provoked my question of whether such a fundamental reconfiguration of professional practice
has led to the emergence of AMHPs as hybrid professionals, as new forms of professionalism
and professional identities can arise from changes that stimulate professionals to reorganise
themselves. These reforms were not only mechanisms for improving public services but also, by extension, mechanisms for achieving government-imposed professional reconfiguration.

The changes introduced by the Mental Health Act (Department of Health, 1983, 2007) disrupted traditional professional boundaries when it contentiously introduced other mental health professionals into the previous Approved Social Worker (ASW) role. Since 1984, ASWs were social workers who undertook additional accredited training to perform specific functions under the Mental Health Act (1983). The new AMHP role extended the ASW role to include other professional groups when the MHA was amended in 2007 from a specialist social work role to a generic mental health multi-professional role. These are first level nurses within learning disability or mental health practice, occupational therapists or chartered psychologists (Schedule 1 - Professional Requirements, The Mental Health (A.M.H.P) Regulations, 2008), although to date no psychologists have trained as AMHPs and social workers are the dominant primary professional undertaking the role. To be eligible for local authority approval, specialist postgraduate training on a course approved by the Health and Social Care Professions Council (HCPC) is required. Of 936 students undertaking AMHP training, 84% were social workers, compared to 14% nurses (Department of Health, 2012), and statutory social work continues to employ over 80% of UK social workers (Moriarty and Murray, 2007; Welbourne, 2011). 96% of AMHPs continue to be local authority employed social workers (Allen et al, 2016); therefore, social workers are the dominant AMHP primary professional. This is interesting given the policy imperatives that sought to extend the primary professional role that took place before, during and following the change from the ASW to AMHP role, and indicates that AMHP work is ideologically and professionally still situated within social work as a profession.
Although the AMHP role is required to enact the Mental Health Act (Department of Health, 2007), the role is often misunderstood or is not widely known about, leading to comments regarding its invisibility (Morriss, 2017). This is implicit in the Care Act (Department of Health, 2014), where the promotion of competition and privatisation, latterly seen in Bath and North East Somerset’s commissioning of Virgin care as the key care provider of social work statutory services, is witnessed (McNicholl, 2016). These policy contexts position AMHP practice within a complex, reactive, resource constrained environment; in some areas, effectively reducing AMHPs to ‘street level bureaucrats’ (Lipsky, 1980) through the gatekeeping of scarce beds and via constraints that arise from the lack of appropriate care and treatment alternatives to in-patient admission.

Over the past decade, major changes in legislation have emerged, e.g. the Mental Capacity Act 2005 followed by the Deprivation of Liberty Safeguards 2008, and the safeguarding adults’ policies now enshrined in the Care Act 2014, all emphasising integrated working to improve service user recovery from mental illness and promote care planning that is person centred. The current policy context of mental health is framed within the strategy document ‘No Health without Mental Health’ (HM Government, 2011), and the subsequent ‘Five Year Forward View for Mental Health’ (NHS England, 2014). They discuss the endemic, widespread inequalities that are known to exist between physical and mental health outcomes (Marmott, 2010; Department of Health, 2016). All have highlighted the need for workforce planning across the entire mental health care pathway to drive efficiencies in how care and treatments are delivered.

Detention rates have continued to rise in recent years, and 2014/15 saw the highest ever year-on-year rise (10%) to 58,400 detentions. There were nearly two million adults in contact with
specialist mental health and learning disabilities services in 2014/5; evidently, the severity of mental health needs and numbers being detained by AMHPs under the Act has increased. A recent CQC report found individuals travelling long distances to hospitals, and that providing alternatives to admissions (a key element of the AMHP role) was significantly constrained by crisis home treatment teams having insufficient time to provide intensive home treatment as an alternative to admission (CQC, 2016). These fragmented pathways have been recognised, with NHS England leading a programme of work to prevent ‘avoidable’ admissions, increase (the now decimated) community provisions and fund new service models (Mental Health Task Force, 2016). A recent pledge by the prime minister to remove the ‘flawed’ Mental Health Act, introducing a new Mental Health Treatment Bill with higher thresholds for detention (The Guardian newspaper, 7th May 2017) is contentious, as it does not account for the serious reductions in budgets for public sector services that have dismantled community provisions that AMHPs rely on when looking for alternative care and support to detention, and the consequent impact on the lives of vulnerable populations such as mental health service users (LGA/ADSS, 2014; McNicholl, 2015).

The debate regarding generic roles versus specialist roles is a longstanding one. However, specialism as opposed to generism is being promoted again by powerful social care and social work organisations, including the Chief Social Worker for England (SCIE, 2008; BASW, 2012; Romeo, 2016). This view is supported by ADASS, who state that generism promotes role overlap and ‘problematic’ weak professional identities, whereas professionals who are specialist professionals are distinctive and have a strong professional identity (ADASS, 2014). These views contradict Romeo’s intention to increase the number of health AMHPs, and her proposal to understand through commissioning research why so few health professionals are training as AMHPs (Romeo, 2016).
Professional identities are best understood in context, and this includes the policy context in which a profession deliver its key functions and duties (Ozga, 1995). There are key events illuminated in policy, legislation and commentaries that impact on AMHP practice. Alongside legislative changes, policies, research and commentaries highlight the pressures placed on AMHPs through increases in workloads, the dismantling of community resources and a reducing workforce (Allen et al, 2016). They highlight a profession that straddles boundaries due to various intentions for generic practices (Rapaport, 2006).

AMHPs practise within organisations that are subject to change. Changes in how organisations function inevitably impacts across the boundaries of professional practice through, for example, the Care Act’s integration agenda, the new bill to replace the Deprivation of Liberty Safeguards, and the Chief Social Worker’s review of AMHP competencies (Romeo, 2016). AMHPs practise within teams, services and organisations. They interface with users of these services and in the complex environment around them. AMHP activity is political as it traverses the public and private domains of life. Understanding these influencing contexts at professional level gives insights into the AMHP role and their identities and is important for understanding the context of HIP study.

2.3 Role identity and role blurring

The impact of changes to structures and institution coincides with new ways of working, where health and social work professionals work in integrated structures recommended in policy frameworks, e.g. National Service Framework for Mental Health (Department of Health, 1999), Refocusing the CPA (Department of Health, 2008) and New Ways of Working (NIMHE, 2007). This has been a feature of the NHS and local authority organisations under
which AMHPs operate. It is now commonplace for mental health professionals to routinely undertake several generic roles, including acting as care coordinators under the Care Programme Approach (Department of Health, 2008), senior practitioners and managers. Both the complexity of specific roles and the broadening out of professionals occupying multiple roles are modern features of health and social care organisations that are enforced and enacted at systemic, institutional, group and individual levels in contemporary society (Noordegraaf, 2015). Reconfigurations of professional work are situated in socioeconomic, demographic, technological and cultural arenas that influence the nature of professional work (Noordegraaf, 2015).

The fragmentation of the structures and institutions that traditionally provided individuals with a framework of stability and predefined elements with which they could identify their professional roles has changed due the policy imperatives described. The erosion and marginalisation of the mental health social work identity remains a concern within the social work profession, particularly when mental health social workers are employed by large healthcare trusts with larger numbers of health professionals within mixed professional teams (Payne, 2006; Rapaport and Manthorpe, 2008; Nathan and Webber, 2010; Allen, 2014). When mental health social workers work within integrated health and social care organisations this is viewed to be detrimental to their professional role in terms of their status and agency, because health colleagues do not value the social perspective and instead they promote a medical view of mental illness (Nathan and Webber, 2010; Allen, 2014). This could ultimately erode the social perspective and provide a one-dimensional view of mental illness (Nathan and Webber, 2010). Nathan and Webber (2010) have expressed concerns that mental health social work has moved on a pathway that has led to a generic mental health practitioner role, arguing this is detrimental to the mental health social work role as it has led
to the role being marginalised within integrated teams. This change in role impacts detrimentally on the professional identities of mental health social workers (and AMHPs) within the mental health trusts to whom they are seconded (Nathan and Webber, 2010). Ineffective team working between separate but professionally related occupations and roles, focusing on matters such as organisational barriers, differences in values, professional self-interest and fragmentation of agency provision, has been found (Hardy et al, 1992). Davies (2003) suggests that despite the promotion of multi-professional team work there is still a degree of hesitancy by colleagues valuing other team members from different professions, particularly as health professionals are viewed as protagonists of the medical model (Nathan and Webber, 2010). These features of professional marginalisation are symbolic of the marginalisation of the social perspective within mental health organisations, and the dominance by NHS agendas and medical professionals within integrated social and health structures (Gould, 2006) in terms of how care and treatment should be delivered to mentally unwell individuals (Evans et al, 2005; Nathan and Webber, 2010). These issues have influenced how the role of the ASW and AMHP has been understood by scholars so far, which is now discussed.

2.4 Understanding the ASW and AMHP role

Evidence suggests that ASWs were largely negative rather than positive about their role being extended to other professionals at the point of transition (Rapaport, 2006, Rapaport and Manthorpe, 2008), fearing domination of the NHS and fragmented identities (Norman and Peck, 1999; Rapaport, 2006; Rapaport and Manthorpe, 2008). Although the Code of Practice (Department of Health, 2015) recommends joint working between professionals involved in MHAA this is problematic, with both ASWs and AMHPs reporting difficulties in multi-
disciplinary and inter-agency work. Poor communication between professionals involved in Mental Health Act work, such as GPs, police and ambulance, was noted as a barrier to effective team working due to availability and resources (Prior, 1993; Manktelow et al, 2002; Davidson and Campbell, 2010).

The previous ASW role was analysed (although not empirically investigated) as complex, involving administrative, legal and psycho-social responsibilities (Bingley, 2005). It involves tensions inherent in exercising aspects of social control and empowerment objectives, whilst also attempting to meet the conflicting needs of service users and carers (Rapaport and Manthorpe, 2008). Thompson (2003) describes the ASW role as conflicted, ‘being through the devil and the deep blue sea’, whilst Gregor (2010) argues the role is a ‘double edged sword’, stressing the complex nature of its care versus control function. Bureaucratic elements of coordination and information gathering are articulated, coalescing with an educational emphasis on social work and AMHP training as skills-based training rather than therapeutic relationship building (Wilson et al, 2008). Whilst the task of negotiating the interface between law, which is abstract and codified, and the social world, which is diverse and unpredictable, is a defining feature of professional social work in modern knowledge societies (Walton, 2000; Noordegraaf, 2007).

The social perspective, a key jurisdictional claim, codified in the MHA (Department of Health, 1983, 2007) and its related code of practice, was found by Gregor (2010) to be significantly underapplied by AMHPs, with fewer than a third of AMHPs highlighting its importance to their practice (Gregor, 2010). However, AMHPs’ values of promoting individuals’ empowerment, applying social models of disabilities, acting autonomously and working collaboratively were found, with both social work and occupational therapy AMHPs
aspiring to address the service users’ holistic needs (Knott and Bannigan, 2013), showing a commonality in the perspectives used by different professional AMHP groups.

In a seminal participant observation study commissioned by the Department of Health, Quirk et al (2000) researched the role of the ASW, eschewing the multifarious, competing roles that ASWs enact within the assessment process contextually deployed. The official legal role is the ‘applicant’, however, other roles are foregrounded depending on the context of the situation and the individual ASW’s working preferences. These roles include ‘Care Manager’, ‘Advocate’, ‘Therapist’, ‘Bureaucrat’, ‘Policeman-Executioner’, ‘Supervisor/trainer’ ‘Hate Figure’ and ‘Impresario’.

The ‘Care Manager’ role is adopted in the context of an existing relationship, where detailed professional knowledge of the person was used to consider the criteria for detention. This role caused the most conflict, as service users reported feeling betrayed by the decision to detain them against their wishes. The ‘advocate’ role exists to advise those detained of their rights of appeal, and in respect of arguing for service users’ rights with other professionals. The ‘therapist’ role is interlinked to the ‘advocate’ role concerning the way the decision for detention was communicated. In certain contexts, the role of ‘bureaucrat’ is seen to minimise the potentially harmful effects that ‘sectioning’ has on existing professional and service user relationships. This role blends into the role of ‘policeman-executioner’, when ASWs are seen to be ‘locking up’ service users in punitive terms against their will’, mirrored by the role of ‘hate figure’ when ASWs are unwittingly cast in this role by the service user and their relatives, who object to detention. The interesting role of ‘Impresario’ concerns being able to ‘stage manage’ the assessment making sure that it runs smoothly, closely aligned with the
role of ‘Contingency Manager’. As MHA assessment is commonly subject to unpredictable and unexpected turns of events, this was a core role that ASWs invoked.

Quirk et al (2000) noted that there were tensions between these roles, such as when the role quickly changes from social worker to ‘hate figure’ once a person is told that they are being detained. Further examples of tensions include signing the application for detention, then encouraging the assessed to appeal against it in the ‘advocate’ role. As one patient commented on his social worker of over five years:

Those are the rules that Brian is under, not the rules that he made. Brian has to follow these rules because he’s employed by the company that deals with situations like that (Quirk et al, 2000, p.45).

Historically, perceptions of ASWs acting as an advocate recur within literature (Quirk et al, 2000; Mankelow et al, 2002; Nathan and Webber, 2010), although many carers and service users did not appear convinced by the advocacy role (Mankelow et al, 2002), reporting a lack of understanding about the AMHP role generally, particularly that it is not explained to sufficient depth even though AMHPs have a crucial role in consulting the nearest relative for the application for treatment (Mankelow et al, 2002). ASWs questioned the extent of their independence during MHA assessment, stating that they felt unable to disagree with the medical recommendations of doctors. Although legally they were the final decision maker, in practice they felt this was difficult, as some ASWs believed that disagreement with the doctors could harm joint working and cooperation (Quirk et al, 2000). This is in opposition to other views expressed, where disagreement with medical opinion is an essential attribute of ASWs’ independence, seen as a counterbalance to prescriptive medical opinion (Huxley et al, 2005). Quirk et al’s (2000) findings link to Gregor’s study (2010), who compares AMHPs’ power to detain to the role of judge:
There is something about being a very human face with quite a bit of statutory power and sitting there face to face with a person, with other professionals wrestling with it and making a judicial decision as ...a mini court on legs (Gregor, 2010, p.435).

Research by Morriss (2017) extended the concept of the multifarious roles AMHPs inhabit by considering the ways social work AMHPs work in liminal spaces, occupying the gaps left by other professions. Her participant Eva is quoted as saying:

> It’s a job about so many hats, isn’t it? It is quite difficult to say what we do and err perhaps you get the feeling that what we do is paper up the gaps in all the other professionals, the bits that are complicated or tricky that’s the bits that ‘oh we’ll get the social worker to do that’ and that’s what we do [laughs] (Eva) (Morriss, 2017, p.1349).

This is similar to my study (Leah, 2012), where Diana described the AMHP role as ‘sweeping up the odds and ends’ to signify the unfinished business that is not part of the legal role that AMHPs routinely undertake. This statement signified the pragmatic parts of the role such as arranging for pets to be cared for, packing clothes for the hospital stay, and securing property. The multifarious roles ASWs and AMHPs enacted were important for examining conceptualisations of AMHPs as hybrid professionals and the ways AMHPs could benefit from hybridisation in their professional practice.

Additional research conducted by Morriss (2016) has conceptualised the socially controlling nature of AMHP work as ‘dirty work’. Morriss (2016) draws on the work of Hughes (1971), who states every occupation develops ‘collective pretension’ to give their work value. This contains activities, some of which might be dirty:

> It may be a symbol of degradation, something that wounds one’s dignity...it may be dirty work in that it in some way goes counter to more heroic of our moral conceptions (Hughes, 1971, p.343).

The ‘designation of the social control function of detention’ is both dirty and prestigious. Her participants viewed AMHP work as advanced social work, and becoming an AMHP was a ‘rite of passage’ for social workers when social workers joined the higher status AMHP
group. Morriss (2016) depicts the ‘dirty’ elements as the ‘damage’ done to service users when detained. Morriss (2016) found that the AMHP role was interrelated with her participants' personal values and professional identity. This was also identified by Gregor (2010), who found that ASWs appeared to:

Embrace and personalize 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).

These ideas underpin what it means to be a certain kind of professional in the sense of recognising the complexities of enacting professional identities. Identity work is therefore pivotal in understanding how AMHPs embed themselves in organisational and professional life. It is through the workplace cultures, socio-political contexts and relational aspects between professional groups, including group affiliations (Goffman, 1959), that professional identities are developed, sustained and enacted dynamically. Scholars have discussed how AMHPs employ narratives that are both congruent and incongruent with a legally defined professional role (Quirk et al, 2000; Rapaport, 2006; Wilson et al, 2008; Knott and Bannigan, 2013; Morriss, 2014, 2015a, 2015b, 2016). Although AMHPs have a fixed role and coherent jurisdiction in terms of making applications for service users’ detention into a psychiatric hospital, they cross-cut several jurisdictional boundaries, specified as legal, bureaucratic, social and administrative in nature (Rapaport, 2006). These boundaries are spaces of inter-professional action and tensions and show how the AMHP role is more than a legally defined professional role, and that AMHPs indeed occupy multifarious roles. The empirical findings of ASWs and AMHPs occupying other professional jurisdictions (Quirk et al, 2000; Rapaport, 2006; Gregor, 2010; Morriss, 2014, 2015a, 2016) are important and therefore incorporated into my conceptual framework in chapter 4, figure 4.6 through the concepts of hybrid roles, boundary spanning and ‘perspectives in use’ to bring meaning and explanation to the AMHP professional role and identities within the HIP.
2.5 Summary

This chapter has summarised the important issues that impact on contemporary AMHP practice, illuminating both the legally defined elements of the role and the empirical research that suggests AMHPs could be conceptualised as hybrid professionals. This will be examined through concepts of 'hybrid professionals' (Blomgren and Waks, 2015) and ‘hybridized professionalism’ (Noordegraaf, 2007, p.773), boundary spanning and the nature of the multifarious roles AMHPs enact in professional practice (Quirk et al 2000; Gregor, 2010) through working in the gaps left by other professionals, in liminal spaces (Morriss, 2014, 2015a, 2016). This is a concept that is incorporated into ideas of boundary spanning (Walter, 2003, Oliver, 2013). AMHPs are drawn from various professional origins and their knowledge areas span other areas of expertise outside of the officially sanctioned role of legal applicant under the MHA (Department of Health, 2007). Hybridity is therefore a concept that can illuminate professional roles and identities in the ways it speaks to formations of new occupational identities, the mixing of multiple identities and how professional roles could be hybridised through boundary working.

As there is no empirical research on AMHP multi-professional identities or on AMHPs as hybrid professionals, my study researches these areas. In doing so I examine previous knowledge of the ASW role, the transition from ASW to AMHP due to policy directions towards generic professionalism and identifies the landscape within which AMHP practice is located. Identity work is pivotal for understanding how AMHPs embed themselves in organisational and professional contexts, as a required new professional is not the same as an enacted new professional (Evans, 2008). These ideas will be built and extended conceptually and will interlink with dialogism, a concept requiring substantive treatment through chapters.
3 and 4, and are summarised by my overarching conceptual framework in 4.6. The following chapter therefore addresses theoretical perspectives of self and professional identities as conceptual resources to illuminate the HIP aims and objectives in relation to AMHP professional roles and identities.
Chapter Three

Locating identities within professional identities

3.0 Introduction

This chapter presents theoretical perspectives of self, social and professional identity as appropriate intellectual resources important for mapping and revealing how AMHP professional identities can be understood. The key points from chapter 2 reveal a multi-professional role that straddles other professional practice jurisdictions, in ways that may be appropriate for understanding AMHPs as hybrid professionals who enact dialogical identities. To understand how professional identities can be examined in the HIP, it is first necessary to understand concepts of self-identity and how this relates to scholars’ perspectives of professional identities, professionality, professionalism and professionalisation. These concepts are appraised within this chapter, with the following chapter illuminating key ideas in relation to hybrid professionals.

3.1 Concepts of the ‘self’

The ‘self’ is derived from an individual’s self-concept, and made from his/her personal identity, derived from a combination of social groupings that they belong to. It is not a distinctive trait possessed by the individual, ‘it is the self as reflexively understood by the individual in terms of her or his biography and is interpreted reflexively’ (Giddens, 1991, p.53; Billot, 2010). Our identity or ‘sense of self’ is not ascribed; it represents an ongoing effort of making sense of who we are, in relation to our past, present and future experiences.
The self is active and created in social contexts, e.g. the workplace. All human socialisation is mediated through socialisation, and language is the mechanism that enables social processes to cross-cut professional socialisation (Holquist, 2002). Identity enactment is a reflexively organised endeavour that occurs in multiple places and allows individuals to sustain coherent biographical narratives. In the context of my study, the self as nested within professional identities becomes a ‘reflexive project’. This involves a form of intentionality that can be understood by drawing on social identity theories (Giddens, 1991; Stets and Burke, 2000; Jenkins, 2008).

### 3.2 Social identity theories

Identity theories were initially introduced and developed within two distinct psychological traditions - American social psychology, which views identity as a principle of social organisation (Goffman, 1959), and psychoanalysis, where identity is a principle of psychological organisation (Erikson, 1970, 1973). Thus, there are different emphases within these traditions on social and psychological aspects of identity formation. As my study is concerned with how identity is formed in social situations such as the workplace, it draws on social identity theory (Goffman, 1959), where identity is a principle of social organisation that divides the concept of an individual’s social identity into two sub-categories, the ‘personal’ and the ‘social’. These are ascribed to individuals through their social interactions with other individuals. ‘Personal’ identity is related to the uniqueness of the individual’s biography, attitudes and habits, whilst ‘social’ identity is acquired via the normative expectations of others, so that others are expected to ‘subordinate’ themselves to these
expectations, and act according to the defined norms of the social context in any given situation (Goffman, 1959; Ashford and Mael, 1989; Barnes et al, 2000).

These normative expectations imply the performance of clearly defined social and professional roles. In conforming to the expectations of others, individuals benefit from group recognition and this in turn leads to the acceptance by other members of a professional group. Socialisation in the work context thus involves accepting roles, and this in turn leads to accepting identities. This process helps the individual to become integrated into a work group, and to display certain features that distinguish one group from another (Goffman, 1959). Individuals can be grouped together in different ways; for example, in multi-professional work groups (community mental health teams) or professional work groups (e.g. social workers, or AMHPs), with identities being shaped through membership of such groups, including how people compare themselves to and differentiate themselves from those in other groups (Goffman, 1959; Tajfel and Turner, 1986; Jenkins, 2008). Several of the ideas of social identity theory are relevant to the study of professionals, i.e. that social identity is a perception of oneness with a group and therefore individuals enact identities through identifying with other people who are part of that group; Goffman (1959) defines this as the ‘in-group’. Other groups defined as ‘out- groups’ are equally important, as people are aware of them and compare their group with other groups to establish a positively valued distinctiveness between the two groups. Competition is common between ‘in-groups’ and ‘out-groups’, with the strength of a person’s affinity further affected by his/her beliefs about the distinctiveness of the group’s values, prestige and practices in relation to those of comparable groups (Tajfel and Turner, 1986, 2001). Different terminology is thus used to interpret identities. Identities are not only normative in relation to roles, but are a representation of our efforts in making sense of who we are in relation to the past, present
and future imagined experiences, as such identities evolve, are fluid and ‘involve a subjective interpretation of our individuality in the context of activities’ (Billot, 2010, p.3).

### 3.3 Concepts of professional identities

Professional identities are dynamically shaped by the social, political and economic circumstances in which a profession is set, subject to change over time and influenced by the interplay of power and privilege in professional roles, exposing roles to various conflicts and tensions. Belonging to an ‘in-group’ affords professionals with lower professional status solidarity and support, which in turn strengthens the ‘in-group’ (Goffman, 1959). This links in with Gee’s (2000) view of ‘affinity’, in the sense of what it means to be a professional within a given institution, what that confers on the professionals, and how it subjects that professional to authorities and jurisdictions (Tajfel and Turner, 1986, 2001; Gee, 2000).

Professional identity is only one type of identity, and my study does not imply that other identities are less important; rather, it is simply the focus of the HIP. Although any attempt to use a definition of professional identities is likely to result in an imposition of sometimes shallow categorisations, such definitions are important anchor points for conceptualisations to be built upon within my study. Professional identities can be defined as:

…the extent to which someone thinks of his or her professional role as being important…attractive and in harmony with other roles…Self presentation and solidarity are among further dimensions of professional identity (Moore and Hoffman, 1988, pp.70-71).
In the above definition, dimensions of professional identities are viewed as congruent with the importance placed by an individual on their professional role and how such a role is harmonious and attractive with other roles enacted. These dimensions, along with the dimensions of solidarity in an individual’s perceptions of their work roles with other individuals with the same work role and the ability to foster self-presentation, are arguably dimensions of professional identity. Additionally, reference can be made between the workplace, individuals and their training and education:

Occupational’, ‘professional’ or ‘work related’ identity as any kind of identity formation process that develop through the interaction between the individual and work context including vocational education and training (Brown et al, 2007, p.13).

These definitions contribute toward how professional identities can be understood. However, these definitions do not account for how an individual perceives him or herself in relation to the professional identities he or she perceives him or herself to enact in given contexts at given times. There is no consensus as to what is meant by professional identity and given the competing nature of the theoretical approaches used to understand it, identity conceptualisations are contestable. As Payne states:

The identity of the profession of social work has often seemed unclear and contested, and social workers in the UK have felt their identity to be bound up in specific roles provided for in legislation, rather than in broader conceptions of their potential role (2006, p.138).

Beddoe (2011, p.27) emphasises the contextual and developmental aspects of professional identity are enacted through a professional’s ‘values, knowledge, beliefs and skills that are shared with others in that profession’, echoing Boussard's (2008) view that a shared professional identity is associated with a shared sense of expertise, underpinned by professional training and socialisation.

Notions of the self enter into concepts of identity in general but are linked to professional identity concepts, through the idea that professional identity is a self-concept. This serves as a
frame of reference for professionals to carry out their professional roles and make significant professional decisions, to ‘take on identities’ through accepted and shared practices and to remain competent as professionals (Brett and Myers, 1999; Taylor, 2008).

Professional identities are thus one of several aspects of social identities, and may be examined through professional group interactions in the workplace, underpinned by how individuals compare and differentiate themselves from individuals in different professional groups (Jenkins, 2008), with the identity of a profession perceived as a collective identity when individuals share goals, resources and joint aspirations of the professional group (Daniels, 2002; Beddoe, 2011).

In new roles, such as the AMHP role with its varied professional origins, how AMHPs individually enact their professional identities through their professionality (Evans, 2008) could illuminate their professional identities. However, what a profession views as worth doing and what its members care about most could guide some professional identities more than the functionalist features of professional regulation and codification (Archer, 2003, 2014).

Ashford and Mael’s (1989) classic study argues there are three aspects to professional identities: (i) distinctiveness; (ii) prestige; and (iii) the salience of out-groups (paralleling Goffman, 1959). Distinctiveness relates to professional values and practice in relation to other comparable groups (e.g. mental health nurses in relation to mental health social workers), regarded as the hallmarks of professional identity (Goffman, 1959; Jenkins, 2008; Webb, 2016, 2017), whilst prestige foregrounds the status, credentials and profession’s reputation and how well received and respected the profession is perceived by others. The
final aspect of out-group dynamics centralises the importance of relational factors, who belongs to the in-group and who is firmly cast in the out-group. Whilst Briggs (2007) proposes that professional identities are underpinned by three concepts: professional identity (what I profess), professional location (my role within the profession to which I belong), and professional role (my role within the profession).

Other scholars argue that professional identities have an embodied existence, with habits and routines embodied in everyday practice. At the professional level, professional identities suggest habitual ways of talking, explaining, perceiving, valuing, doing and assimilating behaviours, knowledge, skills and the values of a profession (Wauckerhausen, 2009; Webb, 2016, 2017). In the post-modern phase identity undergoes constant reconstruction within complex environments and is dynamic over time (Bauman, 2004). It exists on a continuum of the past, present and future and is reflexive and subjectively perceived (Henkel, 2000). It is ‘fluid’ (Bauman, 2004) and ‘part of the lived complexity of a person’s project’ (Clegg, 2009, p.329).

Professional socialisation, interprofessional conflict and tensions, and the impact of jurisdictional issues are examined from a range of empirical studies, and suggest professional identities are located within broad socioeconomic contexts:

Being a professional becomes more than a means by which the individual navigates the increasingly choppy waters of organizational life. Being professional suggests a context of meaning and values, whereby the lawyer, judge...is experientially located through particular narratives and discourse which accrue with and around that identity position (Webb, 2017, p.5).

Even though the human world is socially constructed, it has observable realities that can be specified and empirically researched to understand it. Drawing on Jenkins (2008), professional identities are dialectical processes of collective identification that draw on internal and external
moments, with identification found in the interactions between people who identify themselves in particular ways. Professional identities are ‘achieved’ identities acquired or enacted through life development (Jenkins, 2008). Holland *et al* (1998) emphasise that identity is not a unitary concept but multiple in nature (*identities* rather than *identity*) and is always in a process of becoming:

Because the self is the nexus of continuing flow of activity, it cannot be finalized. It cannot step outside the activity as ‘itself’; the self as it reflects upon its activity is different from the self that acts…The self-authors itself and is thus made knowable, in the words of others (Holland *et al*, p.173).

In authoring the self, we make reflective choices about how we enact our identities. This narrative identity is mediated by practice in professional roles. Identities are not just achieved, they are enacted through engagement in an activity that entails performance and, in turn, recognition by others. Identities are visible in discursive spaces; for example, during MHAA. Espoused identities are enacted within given contexts, such as the workplace, and within the purpose of work-based conversation; that is, that identities are ‘dialogical’ (Holquist, 2002), a concept that requires substantive treatment and is considered in detail on chapter 4.

### 3.4 Interpretations of professionals, professionalism, professionalisation and professionalities

The sociology of the professions has been extensively researched, with how scholars define and conceptualise professionals changing over time. Within contemporary debates, scholars have divergent perspectives and conceptualisations of the terms professionals, professionalism and professionalisation. These terms will now be examined.
One consequence of the reform to the MHA 2007 was the professionalisation of AMHPs (the term ‘professional’ entered the AMHP title from the previous Approved Social Work title, when it was introduced within the amended Mental Health Act in 2007). AMHPs are a new form of public professional. When professional associations are successful in (re)making a new professional, as witnessed by the change from the ASW to AMHP role, the enactment of change can involve changes in jurisdictional boundaries (Noordegraaf and Van der Meulen, 2008). The mechanism for (re) making professionals, according to Noordegraaf and Van der Meulen (2008) comprises cognitive (training focused on knowledge and skills), normative (membership and selection criteria, codes of conduct, and disciplinary sanctions) and symbolic (professional narratives, service ideals, rites of passage) aspects. These mechanisms offer a conceptualisation that supports professional distinctiveness as ‘pure’ professionals. Yet, social workers and nurses are not classic or ‘pure’ professionals; rather, they are ‘practical, semi-welfare state professions’, because they are less well established and do not have the defining features of ‘pure’ professionals (Noordegraaf, 2011, p.470).

The work of Noordegraaf (2007, 2011, 2015) makes a valuable contribution to conceptualisations of professionals and professionalism. Noordegraaf (2007) presented an analytical framework for summarising the reconfigurations in the professionals he identified from differing and broad professional areas, including social workers. He categorised professionals into a typology comprised of ‘pure’ (‘pure, pressured, purified’), ‘situated’ and ‘hybrid’ (‘hybridised’ and ‘mixed-up’) professionals. ‘Pure’ professionalism is typified by trait-based approaches, with membership drawn from classic occupations, traditionally founded upon guild membership, e.g. doctors and lawyers, that are ‘knowledge intensive’, but whose knowledge is based on positivistic epistemologies of rationality, science and universal truths. These are perceived as the ‘real’ professions (Noordegraaf, 2007, p.765) because they
are also highly specialised and their intellectual labour can be codified. The boundaries of a ‘pure’ professional’s practice is clear, with borders defined through the formation and standardisation of their own professionally driven professional associations, and a university education based on developing ‘expertise’. Noordegraaf’s (2007) interpretation in part synthesises trait based understandings of professionals (Abbott, 1988; Freidson, 2001). Accordingly, trait based interpretations argue that professionals are regarded as occupations with distinct characteristics, including, a lengthy period of education and training, a high degree of professional autonomy; a clear code of conduct and practice, a strong voice in determining policy and amendments to practice and law, a specialised knowledge base, clear boundaries between members and non-members, and a formal qualification (Hoyle, 1975; Abbott, 1988; Friedson, 1994; Hoyle and Wallace, 2005; AMHP Regulations, 2008; BASW, 2012; CQSW 2016; Webb, 2017). This conceptualisation keeps the boundaries of ‘professional’ located within ‘traditional professional occupational fields’ (Noordegraaf, 2007).

This trait based view of professionals is now discredited (Evett, 2003; 2013). Society has moved on and there are wider influences at play that constrain professional powers through governmentally led and organisationally imposed agendas that confound the ambiguities witnessed in modern day professional practices (Karreman et al, 2002). These are the ‘fuzzy service realities’ of professional life (Noordegraaf, 2007, p.770). Previous knowledge societies have evolved into network societies with an emphasis on flexible boundaries that are blurred, and although network societies expect professionals to behave as ‘pure’ professionals through professional practice, pure professionalism is weakened through organisational control and boundary fluidity (Bauman, 2011; Noordegraaf, 2015).
‘Situated’ professionalism differs from ‘pure’ professionalism as it mixes up ‘pure’ professionalism’s features but introduces elements of organisational control (Noordegraaf, 2007). The organisational control elements comprise the consideration and imposition of efficiency, financial and resource agendas (Flynn, 2004; Harrison, 2004). Professionals are embedded in organisational systems and this is a key aspect of their professional practice. These are ‘professionals within, for instance, public service delivery who operate within organisational…boundaries but who remain professional’ (Noordegraaf, 2007, p.773). The idea of ‘situated’ professionalism was extended to include experts, within ‘an age of expertise’ (e.g. Brint, 1994, p.40), and was not restricted to traditional professionals. An ability by professionals to solve problems, underpinned by training and skills that are highly regarded by services (not by traditional professionals themselves) i.e. as modern experts (Brint, 1994, p.40) was a key component.

The concept of ‘hybridised professionalism’ is an attempt to reinterpret professionalism and to reflect the contemporary landscape in which professionalism is practised (Noordegraaf, 2007, 2011). It is defined by a focus on professionals who are reflective practitioners, e.g. Schon’s (1983) managers, and broadened out to include a less restricted use of the term professional that values ‘artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness and values conflict’ (Schon, 1983, p.49). It is a relational concept, which requires ‘interdisciplinary knowledge and interactive skills’ (Noordegraaf, 2007, p.775):

Hybrid professionalism connotes a ‘new’, more accessible, more democratised form of professionalism that includes what has come to be known as reflective practice (Evans, 2013, p.482).

Hybrid professionals are arguably adept at operating within ambiguous public domains that are not easily organised. They can act in complex settings that have hybrid organisational forms
(e.g. health and social care trusts). Their work is attached to circumstantial societal change that shows responses to contextual factors involving symbolic and cultural meaning making and ‘their links with outside worlds are part of their professionalism’ (Noordegraaf, 2007, p.771).

‘Mixed up professionalism’ is a reinterpretation of hybrid professionalism, required because of the experiential and inferential nature of present day professional work (Noordegraaf, 2007). Social workers, for example, are required to operate under market-orientated conditions, so that notions of professionalism enacted through daily practice encompass performance measurement. They are required to become ‘managers’ of sorts, e.g. social workers, nurses and occupational therapists employed under the role of care manager, bridging both their professional and managerial role to delivery efficient costed care packages (Lymbery, 2000). Significantly, hybridised professionalism is viewed as a means of bridging ‘expertise-induced gaps between professional control and managerial control’ (Noordegraaf, 2007, p.776). From the perspective of ‘hybridised professionalism’ professionalism is used as a performance ‘amidst constraining, confusing and fragmented realities’ to preserve and predict via professional socialisation a ‘normative social order in work and occupations’ (Evetts, 2006, p.137). It has the capacity to improve the content of control; in other words, hybrid professionalism is a way of controlling complex public service work, of controlling complexity, ambiguity and contested professional domains where boundaries are in flux. Hybrid professionalism ‘is perceived as professionals engaging in reflexive control...it is about controlling the meaning of control, organizing and professionalism’ (Noordegraaf, 2007, p.775); i.e. it is possibly experiential and an attempt to bridge gaps in expertise, to control ways in which expertise is controlled. When professional and managerial boundaries are in tension they become blurred and contested, leading to hybrid professionalism (Noordegraaf, 2015). This is when professional practice becomes positioned within resource constrained
environments that are managed, restraining the opportunities for professionals to exercise autonomy, yet also respecting and promoting professional practice ironically.

The core aspects of ‘hybrid professionalism’ defined by Noordegraaf (2007) in summary are:

1.) Linkages between work and organised action
2.) Mechanisms for legitimating work
3.) Searches for occupational identities

Work that involves dealing with trade-offs is a common feature, arising from coping with service users’ requirements in the face of financial constraints and reduced capacities. Fundamentally, professional work in health and social care services is at odds with the inferred nature of casework. Due to these changes in how professionals and their professionalism can be conceptualised, links can be made to identities. As Noordegraaf (2007, p.780) states, ‘the search for present day professionalism is a search for...appropriate work identities’ (my emphasis). However, sociological definitions of the distinctiveness of professionals versus other occupations have been somewhat difficult to differentiate between (Evetts, 2013, p.781). A different way of conceptualising professions is to view hybrid professionalism as a response to the uncertainties experienced in contemporary life, in risk societies (Evetts, 2006; 2013), comprising professionals’ ability to enable service users and carers to deal with risk using expert knowledge within organisational and occupational arrangements (Noordegraaf, 2007).

In summary, hybridised professionalism is ‘highly relevant in mixed occupations’ (Noordegraaf, 2015) such as AMHPs, where meaningful connections are required between service users’ public and private domains, where issues are ‘soft’ and there are multifaceted
interactions that require linking ‘street level work’ with organisational and professional worlds (Lipsky, 1980).

The second concept of importance to the HIP is that of professionalism. Professionalism has been interpreted as normative or as an occupational value that workers promote and value (Evetts, 2013). The contemporary interpretation of professionalism as a value system places an emphasis on professional expertise, expert judgement, analysis of risk and a service user professional relationship based on values of trust and professional discretion (Evetts, 2006; 2013). AMHPs are public servants and exercise legal duties as ‘agents of the state’ (Nissen, 2010). Public service professionalism is arguably expert based (O’Reilly and Reed, 2011).

Several interpretations focus on professionalism being externally imposed rather than subjectively enacted. BASW (2014) vaguely defines professionalism as ‘identifying as a professional social worker’, and the standards for Employment for Social Work England state employers should ‘recognise and support the professional identities of social workers within your organisation’ (Local Government Authority, 2014), arguably acknowledging the perceptions that social workers’ professional identities are weakened due to working in integrated structures of health and social care, and that the parameters of social workers’ role, remit and its boundaries of responsibility are ambiguous and in flux.

It is problematic to consider only pure models of professionalism, because they do not fully engage with the changing contexts in which professionalism is enacted and in which professional identities are espoused. The meaning of professionalism is clearly contested, with ‘professionalism meaning different things to different people’ (Fox, 1992, p.2). Professionalism is socially constructed, and professionals themselves are a key part of that
construction. Professionalism is partly comprised of professionals’ commitment to being professional thorough the exercise of values, professional pride and work based satisfaction (Evetts, 2013, p.785). AMHPs do have autonomous decision making duties enshrined in the MHA (1983, 2007), which Evetts (2013, p.786) suggests is ‘part of the appeal (or ideology) of professionalism’. However, this appeal is contradictory, because although it is welcomed and viewed as attractive by professionals because it is perceived as way of bringing about professional satisfaction with work conditions, it is mostly a means of organisational control of professionals by managers. McClelland (1990, p.107) differentiated between professionalism ‘from within’, where professionals organise the market (e.g. lawyers and doctors), and professionalism ‘from above’ (e.g. social work), where professionals are dominated by external factors. Where professionalism is imposed from above it is being used to cajole professionals into behaving in ways that the organisation perceives to be important, based on organisational perceptions of efficiencies and institutional ideas of effectiveness. Organisational imperatives define professional service user relationships. This conceptualisation of professionalism, defined as ‘organisational professionalism’, is particularly relevant to public service professionals, whilst ‘occupational professionalism’ is based on professionals’ use of autonomy and discretionary judgement in the management of complex cases and the development of strong identities (see Evetts, 2013 for a full discussion).

Located within discourses of professionalism is the focus on working with ambiguity and in contexts of complexity and uncertainty. Such contextual factors ‘call for an ambivalent understanding of present day professionalism’ (Noordegraaf, 2007, p.771). Professionalism can be perceived to be both pluralistic and individualistic, comprising the attitudes and behaviour an individual possesses towards their own profession (Boyt et al, 2002, p.322), with performance indictors via management structures that monitor accountability a key component
of professionalism in contemporary knowledge based societies (Evetts, 2003). Professionalism is defined by Evans (2008, p.29) as:

Practice that is consistent with commonly held consensual delineations of specific occupational group and that both contributes to and reflects perceptions of the groups purpose and status and the specific nature, range and levels of service provided by, and expertise prevalent within, the occupational group, as well as the general ethical code underpinning this practice.

This notion of professionalism is predicated on an understanding of ‘commonly held consensual delineations’ within specific occupational groups. Through focusing on the ‘consensual delineations’ of professionalism, this definition does not incorporate the contested nature of professionalism within occupational groups, given that occupational group perceptions of consensual delineations have been shown to differ (Frost et al, 2005; Beddoe, 2010; 2011), although it does illustrate important distinctions in relation to group expertise, levels and range of services provided, supported through ethical practice. The concept of ‘proficiency’, in contrast, is individualistic (Evans, 2008), and incorporates influences on professional practice.

Professionality, a term introduced by Hoyle (1975) and extended by Evans, is:

An ideologically-, attitudinally-, intellectually-, and epistemologically- based stance on the part of the individual, in relation to the practice of the profession to which s/he belongs, and which influences his/her professional practice (Evans, 2002, pp.6-7).

This definition accepts the parameters an individual’s views of how they enact their professionalism through their professionality. Thus, professionalism can be viewed as the merge of multiple professionalities, and to be meaningful must illuminate everyday practice realities; it is enacted through ‘ironies of adaption’ and ‘ironies of representation’ (Hoyle and Wallace 2007, pp.18-19). ‘Ironies of representation’ manifest in the ways professionals present an image of the organisation to the outside world that is incongruent with the reality of its daily practices. Irony is inevitable because the ‘official’ versions of professionalism are predicated upon a commonality of professional-related behaviour that an empirical study of
professionality reveals to be unviable; therefore, ‘notions of professionalism, in representing something that is unviable, career towards nonsense, questioning the ironies under which professionals work to enact their professional identities’ (Evans, 2008). ‘Ironies of adaption’ entails improvising and negotiating expectations to better meet the perceived needs of service users in contingent circumstances. The excavation empirically of the imperfect practice situations encountered by professionals, the ‘twists and turns’ involved in navigating complexities often through improvisation, is key concern of the HIP.

Professionalisation is the term usually applied to denote the process by which professions achieve the status of a profession and become accepted as a profession (Hoyle, 1975; Evetts, 2013). The concept of professionalisation (Evetts, 2013, p.782) is important in any analysis of newly emerging occupations, such as the AMHP. Professionalisation is arguably a complex and interactive process learnt by professionals through their education, training and work based socialisation. It is:

a normative value system in the socialization of new workers, in the preservation and predictability of normative social order in work (Evetts, 2003, p.404).

In relation to AMHPs professional socialisation takes place via practice based placements and a professionally certified programme of study regulated through the HCPC. Once learnt, the knowledge, skills, values, attitude and competency requirements characteristic of the profession are internalised (Abbott, 1988; Evetts, 2013; Webb 2016, 2017). Though important, formal qualifications alone are not hallmarks for becoming a fully-fledged member of a profession. The professional must also act according to the cultural dimensions of a profession. This includes ‘talking as we do’, using the language of the profession, concepts, phrases, terminologies, perspectives used in its everyday dialogue, and understanding and explaining things as recognised members of the professional group. That means telling types of stories, typically told, not only about a profession but about
neighbouring professions (Shulman, 2005). It is through cultures of socialisation that professional roles and identities can be studied empirically, including those ‘imposed’ on professionals from regulatory bodies and organisations who exert powerful influences on professionals, in part through codification and regulation. Such organisations hold professionals accountable for their professional actions through influences arising out of policy and political imperatives, such as New Ways of Working in Mental Health with its focus on generic professionalism (NIMHE, 2007).

Given the importance of how professions make sense of their work, ideas of professionals, professionalism, professionalisation and professionality are incorporated into my conceptual framework in 4.6. Drawing on Hoyle and Wallace’s work (2005), there are ironies involved in enacting a professional role and professional identities. This is the process where a profession has clear understanding of its regulatory and competency requirements, and enacts this understanding through the boundaries of professional practice in public service that manifest in changes between the officially sanctioned ways of practising and practice as it is experienced contingently. These aspects of professionalism refer to the process of maintaining and improving knowledge and skills, prioritising service user needs and enhancing the quality of provision (Hoyle & Wallace, 2005, p.100; Evetts, 2013). These aspects of professionalism arguably relate to a ‘dialogical’ component, where professionals dialogically enact their identities with other professionals through ‘dialogic exchanges’ (Holquist, 2002, p.69), illuminating how AMHPs could improvise (Holland and Lave, 2000) and how this interrelates with ‘ironies of representation’ and ‘ironies of adaptation’ (Hoyle & Wallace, 2007) when AMHPs engage in talk with other colleagues during MHAA. Thus, dialogue becomes a way of having professional work recognised by professionals.
3.5 Summary

Given the growing hybridisation in public sector services (Hope, 2005; Hurley and Linsley, 2007; Hood, 2012; NHS England, 2014; Kirkpatrick and Noordegraaf, 2015; Noordegraaf, 2007, 2015), the ideas discussed previously link to ideas of hybridity. Hybridity may provoke changes in professional roles and identities. The mixing of multiple roles (such as a nurse, who is an AMHP, a deputy manager and a care coordinator) or the construction of new identities (a nurse becoming an AMHP, acting as one and being accepted as part of the in-group) (Goffman, 1959) presents interesting and contemporary empirical challenges, relevant to the study of AMHP professional identities. Professionalism is something professionals want to do; in enacting what they want to do, they are shaping their professionalities and their position as a professional within it, both individually and collectively as part of a professional culture, through their attitudes and behaviours and through their dialogue with other colleagues. I recognise that professional uniformity and standardisation is a ‘fool’s errand’ (Willis, 2000), as professional inter-subjectivities partly mitigate standardised approaches to contextually driven work encounters. In practice, professionalism is complex and dynamic, affected by contexts, local and national, and is creating hybridisation (Walter, 2003; Noordegraaf, 2007, 2015; Tate, 2007; Nissen, 2010). Increasingly, professionalism is becoming conceptualised as ‘hybrid professionalism’ (Noordegraaf, 2007, 2015; Kirkpatrick and Noordegraaf, 2015).

As professional identities evolve over time, studies that investigate them longitudinally (like this study) can generate important insights into how professional practices are sustained and developed empirically by studying a profession’s knowledge, skills and values claims. Any
meaningful conception of professional roles and identities must reflect the realities of everyday practices. It is both a theoretical and an empirical concern.

The following chapter therefore investigates the gains made through hybridity as a framework for examining AMHP professional roles and identities. Ideas of hybridity are important given the integration of social and health care organisations within which AMHP work is practised, espoused and situated. Although the specific concept of hybridity is still underdeveloped (Denis et al, 2015), increased hybridity has important implications for AMHPs. A broad approach to investigating hybridity is taken in the chapter that follows, where I outline what hybridisation means, why it is a relevant conceptualisation for the study of AMHP professional roles and identities, and how it interrelates with ideas of dialogism (Holquist, 2002).
Chapter 4

Hybrid Professionals and Dialogism

4.0 Introduction

This chapter considers hybridity and dialogism as appropriate conceptual tools to investigate AMHP professional identities. Ideas of hybridity and dialogism are important because AMHP professional practice occurs in the context of negotiated multi-professional activity, involving professionals having conversations (hereafter termed ‘dialogic exchanges’) (Holquist, 2002) with other professionals to achieve care and treatment outcomes. Negotiation in this context refers to how professionals influence the course of events to achieve professional outcomes. Professional identities are dialogic, because the professional self is always experienced in relation to others (Holquist, 2002), in similar ways to Goffman’s (1959) conceptualisation of ‘in and out-groups’ and Jenkin’s (2008) theorisation of ‘sameness’ and ‘difference’.

Dialogism is a key theory, because conceiving identities dialogically means that realities of professional practice are always experienced, not just perceived, and, importantly, that practice is experienced from a position. In this study, I am interested in the experienced (in dialogical terms) position of being an AMHP and what this means for AMHP professional identities. The concept of ‘dialogue’ interrelates with concepts of hybridity, as hybridity is enacted through dialogue with other professionals and service users, and within and between other organisations in the context of Mental Health Act duties. Hybridisation arguably involves AMHPs organising how they negotiate their role and how they enact their professional identities within a defined professional role. Practice is contextual and subject to a multitude of complex demands. The
concepts of ‘dialogue’ (Holquist, 2002) and ‘improvisation’ (Quirk et al., 2000) are key ideas for examining how AMHPs navigate complex practice contradictions (Garsten, 1999; Holland and Lave, 2000; Quirk et al., 2000; Friedson, 2001; Solomon et al., 2016). The structure of this chapter is as follows. Firstly, I define positions on hybridity, making the case for why hybridity is an important lens for examining AMHP professional identities, located within ideas of being a professional, professionality and professionalisation and linked to the concept of dialogism (Holquist, 2002; Evans, 2008). Secondly, I locate hybrid perspectives with hybrid professionals, and finally I consider ‘ironic dialogism’ as a means of navigating the inherent contradictions that enacting hybrid roles and identities invoke.

4.1 Why hybridity is an important lens for the HIP

The concept of hybridity is a significant lens for examining AMHP professional identities as hybrid professionals, as previously discussed. To repeat from chapter 2, AMHPs are drawn from three distinctive professional origins. This is unusual and interesting in terms of espoused identities, and the nature of their role involves working within and across other professional roles, organisations and structures in ways that cross-cut traditional jurisdictions of professional practice in novel ways. I will consider in turn definitions of hybridity, the process of hybridisation (and the ways this is interrelated to professional practice jurisdictions), hybrid roles and boundary crossing.

4.2 Definitions of hybridity

Scholars’ definitions of hybridity and their conceptualisations offer different positions on the manifestation of professional (and often managerial) hybridity. A key area of agreement is
that hybrids merge different and potentially contradictory sets of values and features (Croft et al., 2015; Noordegraaf, 2015). The possible incompatibilities of values are what make hybrids such. Hybridity refers to a situation of ‘mixed origin or composition’ (Gittell et al., 2010), visible in individuals’ professional roles and identities (Denis et al., 2015; Croft et al., 2015; McGivern et al., 2015; Spyridonidis et al., 2015; Waring et al., 2015). AMHPs are drawn from professionally diverse groups; they are of a ‘mixed’ professional origin. However, the primary professional backgrounds of AMHPs may not in themselves illuminate hybridity empirically or theoretically. Hybridity is a complex concept, subject to numerous interpretations, and it operates on multiple levels. However, it is the focus on hybrid roles and identities at individual level that the HIP is concerned with (Denis et al., 2015). Hybridity is a concept that can illuminate professional identities in the ways in which it speaks to changes and formations of new work identities, the mixing of multiple identities, how professional roles may be hybridised through boundary working and how this is enacted by professionals in discursive spaces, e.g. during MHAA.

Hybrid professionals are perceived as both occupying hybrid roles and complex identities (Croft et al., 2015; Spyridonidis et al., 2015) embedded in different professional groups (Byrkjeflot et al., 2014; Spyridonidis et al., 2015) as an enactment of wider changes at individual level on professionals and groups in public service (Waring, 2015), with hybridity further signifying the liminal space between two or more original approaches (Croft et al., 2015; Waring, 2015). In terms of professional roles, hybridity refers to mixing of two or more professional roles, e.g. the ‘hybrid manager’ in the medical profession (McGivern et al., 2015), ‘physician executives’ in the USA (Hoff, 2000) and the emergence of the ‘care navigator’ under the Care Act (2014) in health and social care. Hybrid professionals are professionals who straddle several professional roles or who cross-cut traditional professional
boundaries when they enact multiple roles (Weinrach, 2001; Warrington et al, 2004; Noordegraaf, 2007; Oliver, 2015). Studies of hybrid professional roles (McGivern et al, 2015; Spyridonidis et al, 2015; Waring, 2015) explore hybridity in public service organisations on multiple levels, including types of hybrid roles, from incidental to willing hybrids, with willing hybrids reconstructing ideas of professionalism as involving and valuing interprofessional team work, because it focuses on delivering the best service for patients (McGivern et al, 2015). The way this is organised is driven by values of what best patient care looks like (McGivern et al, 2015).

Distinguished from notions of hybrid professionals as ‘professionals who operate within broad knowledge areas, who have developed competence outside of their main area of expertise, and are likely therefore to bridge divergent logics’ (Blomgren and Waks, 2015, p.79) is the concept of ‘hybrid professionalism’ previously conceptualised in chapter 3 (Noordegraaf, 2007, p.775) as ‘meaningfully managed professional work’ (Noordegraaf, 2015, p. 11) which professionals themselves organise at various levels across various organisational structures, including working with individuals with complex health needs (Barr-On, 1994; McGivern et al, 2015). Hybrid professional influence within complex organisations, according to this view, means that professionals are not fully subjected to increased managerial control but are instead ‘lords of the dance’ because they are able to influence changes in institutional arrangements (Scott, 2008). Hybrid professionals are professionals who are occupationally located in roles and areas of expertise that involve negotiated practices that cross-cut traditional boundaries (Noordegraaf, 2007; McGivern et al, 2015; Spyridonidis et al, 2015), so that professional identities that are hybridised are congruent with negotiating professional outcomes when working in joint health and social care organisations.
In jointly managed organisations, ‘pure’ professional identities are inviable due to exposure to knowledge from other professional disciplines and integrated structures (Aldrich and Herker, 1977; Abbott, 1988, 1995; Aldrich, 2004). The idea of an ‘extended’ professional who works within mixed structures includes an understanding that such professionals commonly embrace a *breadth of perspectives*, integrating differing ideological stances situationally and contextually (Noordegraaf, 2007; Denis *et al.*, 2015). Differing (and possibly competing) perspectives enable inter-professional working, and it is arguably the *breadth of knowledge* that gives hybrid professionals scope and permission to cross professional boundaries:

In the case of professional fields tied to welfare states and organizations such as …social work…(these) professional groups embody more hybridity…in terms of principles for structuring and empowering work (Noordegraaf, 2015, p.4).

The idea of liminality is a feature of hybridisation. Walter (2003) generates an integrative perspective in the art-or-science debate by setting out a performance theory developed by the collaborative works of scholars from a variety of disciplines, including anthropology, sociology, theatre arts, literary criticism and linguistics. Discussing the relevance of postmodern performance theory to social work, Walter (2003) argues that ‘a postmodern performance perspective on the art-or-science debate in social work brings forth how these terms were used in an either/or tradition of thinking’ (p.317). The dichotomist thinking of social work scholars who represent social work as either art or science conceals the space that lies between art and science, referred to as the ‘third space’, where social work exercises its ‘hybrid identity’ as both art *and* science (p.319). AMHPs (most of whom are social workers) could belong to the third space, made visible through research that investigates hybrid perspectives. Research that accesses the scripts that AMHPs use in their daily practice and the stories told offers scope to illuminate hybrid professionals and their identities. Language used could be ‘borrowed’ from various professional fields, e.g. from medicine, in the use of
the word ‘patient’ rather than the social work term ‘service user’. Abbott (1988) links interstitially to professionals’ ‘professional jurisdiction’; that is, the control professionals have over which work they can undertake that is dependent on their ‘underpinning knowledge, their regulation, and by certain “traits” that mark them as a particular and special kind of occupation’ (Abbott, 1988, p.547). Abbott’s (1988) ideas of ‘institutional work’, can be linked to the everyday ‘purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions’ (Lawrence and Suddaby, 2006, p.215). Institutions and identities are fundamentally interrelated. Identity work is a form of institutional work, because ‘identities describe the relationship between the actor and the field in which that actor operates’ (Lawrence and Suddaby, 2006, p.223). The idea of professionals operating with broad knowledge areas reoccurs within social work professional identity articles (Auslander, 2001; Beddoe, 2011), with consideration given to social work’s ‘holistic perspectives’ and within the AMHP role to the ‘biopsychosocial model of mental health’, a model that integrates distinctive perspectives that span social, legal, psychological and medical domains of mental health practice (Auslander, 2001; Beddoe, 2011). AMHPs traverse these perspectives, and as such AMHPs could occupy multi-professional jurisdictions.

4.3 Boundary spanning

Distinct from definitions of ‘hybrid professionals’ (Blomgren and Waks, 2015, p.79) and ‘hybrid professionalism’ (Noordegraaf, 2007, 2015) is the concept of boundary spanning. Whilst hybrid professionals operate within broad knowledge areas and have competence perceived by others as being outside of their areas of expertise, boundary spanners are professionals operating at the boundaries of their organisation, mediating between it and
wider societal structures, who practise competently with a variety of other professionals, often within areas managing risk, but who do not share their organisational and/or professional identities (Aldrich and Herker, 1977; Bar-On, 1994; Walter, 2003; Nissen, 2010; Beech, 2011; Oliver, 2013). Boundary spanners integrate different perspectives into their work through dialogue that involves negotiating shared goals and meanings amongst diverse groups (Williams, 2002; Nissan, 2010; Beech, 2011; Oliver, 2013). Steadman’s (1992) examination of collaboration between mental health and criminal justice systems defined boundary spanners as those who:

...had carved out niches in their organizations that depended upon a special set of skills they had acquired to smoothly, albeit carefully, crosswalk the three, often competing, systems of corrections, mental health, and the courts (p.76).

Like Nissen (2010), I define boundary spanning within my study, which is an accepted form of hybridity (Nissen, 2010; Oliver 2013), as professionals whose role it is to work between systems and whose goals, though superficially complementary, may carry inherent conflicts requiring mediation, negotiation and strategy. AMHPs are well placed to be conceptualised as boundary spanners because their role spans the kind of organisational boundaries envisaged by Steadman (1992). Boundary spanning is salient for AMHPs because AMHPs tend to conceptualise systems broadly. The individual, family, community, organisations and society all constitute systems. AMHPs engage in work that occurs in places completely controlled by other organisations, such as police stations, prisons, accident and emergency departments, and outside of organisations in the private domain of service users’ homes. AMHPs reconcile conflicting and divergent professional views, coordinate the collective professional group, and could provide a means of connection through dialogism with GPs, psychiatrists, ambulance crews and bed managers in the best interest of the service user. This feature of hybrid professionalism has been found elsewhere (Blomgren and Waks, 2015, p. 94). This public versus private domain of AMHP jurisdiction is a significant area of identity
work. Enacting hybridity could be a way of AMHPs articulating professional identities at the intersection of these systems dialogically.

Whilst relationship-building is a core skill in many professions, the added challenge for boundary spanners is that they must, by definition, build relationships with people who are different from themselves (Williams, 2002; Nissen, 2010; Oliver, 2015). For this they need to be able ‘to acknowledge and value difference in terms of culture, mind-set, (and) professional role’ (Williams, 2002, p. 110), to competently work in different contexts with a variety of workers with different professional roles and identities. In inter-professional work, ‘living with difference’ (Frost et al., 2005, p. 190) is a key competence, and includes accepting the limits of what, for each profession or discipline, contributes to shared practice. It necessitates an honest interrogation of the different perspectives that professionals enact and espouse. Boundary spanners need to know how to illuminate difference and how to manage the conflict that often results (Klein, 1990; Nissen, 2010). This is familiar terrain in AMHP practice, particularly as the commitment to diversity, social justice and the intrinsic worth of all people is written into the profession’s ethical code (AMHP Regulations, Department of Health, 2008; MHA Code of Practice, 2016).

Professional identity is interactive, and viewed in relation not only to what the professional knows they must do, but significantly in relation to what others are supposed to do, thereby defining through ‘dialogic exchanges’ with other key professionals the jurisdiction of professional practice (Wieck et al., 2005). Boundary spanners are adept in exercising the kind of non-hierarchical, facilitative leadership for which highly developed communication and interpersonal skills are required (Steadman, 1992; Williams, 2002; Nissen, 2010). It is particularly important that these skills can be applied to a whole group or network (Klein,
through ‘persuasion and friendly influence’ (Weick et al., 1989, p.350; Quirk et al., 2000) to effect change. Boundary spanners’ primary means in securing allies and resources that cross-cut traditional boundaries is through negotiation skills and collaborative relationships, applied both to individuals and the networks in which they operate (Oliver, 2015). As such boundary spanners are ‘agents of change’; a ‘boundary spanner must learn to address, deconstruct and eventually help to more fruitfully reconstruct ... tensions within and across systems’ (Nissen, 2010, p. 379). This necessitates some critique of existing relationships and processes and a willingness to experiment with emergent alternatives. Exemplar boundary spanners are rule-benders and risk takers (Klein, 1990; Williams, 2002). They must be prepared to cross boundaries to be effective, to operate on the edge of what is comfortable and known. The ideal boundary spanner is:

...an open-minded person with the ability to take risks without being strident or careless; to have vision, but stay practical; to be courageous while attending to the politics; and to systematically create and nurture infrastructure for support and guidance (Nissen, 2010, p.381).

The boundary spanning approach provides conceptual support for engaging with multiple roles and working across fields of practice (Kerson, 2004). In this way boundary spanning is interrelated with hybrid roles.

The gains made through conceptualising AMHPs as boundary spanning hybrid professionals and framing this as a core element of professional identities are clear. AMHPs navigate real world problems that are extremely complex, enmeshed and dialogically enacted. As Roy argues, ‘the real problems in society do not come in discipline-shaped blocks’ (Roy, 1977, p. 163 in Klein, 1990, p.35). Complex problems cross professional, disciplinary and organisational boundaries and require complex responses that do the same (Williams, 2002; Hood, 2012). These ideas have resonance in the fields of health and social care (Adams et al., 2006). They have led to a growing public policy commitment in health and social care to
‘joined-up working’ and integration across roles, teams and organisational structures (Denis et al, 2005; Frost et al, 2005). This in turn has renewed interest in boundary spanning (Masterson, 2002; Williams, 2002; Oliver, 2013).

Hybridity could be enacted in AMHP roles and in their espoused identities that draw on professional perspectives, such as the social perspective, and through their professional actions; hybridity could be present within ‘dialogic exchanges’ that occur in professional conversations. (Holquist, 2002; Beech, 2008). These areas where hybridisation is possible arise from contentions within professional practice areas, that structure and restructure working arrangements; what AMHPs do that is required of the role by competency frameworks and codified in law and what they do that is practical, pragmatic and necessary that involves doing work outside of their jurisdiction in ways that encroach into other professional areas, as hybrid professionals. How they encroach into other professional jurisdictions is, however, arguably achieved through dialogue.

4.4 Dialogism

Drawing on Bakhtin (1981) in Holland et al (2005), hybridisation is a way of professionals taking an:

...authorial stance in the orchestration of multiple voices; refiguring the space of authorship, multiplying the possible way of identifying activity (p.315).

This means that identities are pluralistic, dialogical and visible in events (activities). This captures the significance of investigating hybrid professionals through the lens of dialogism. ‘Dialogism’ is a concept situated in social and professional practices that locates individual identities in time, space and places (Beech, 2008). Individuals occupy events that are either responded to dialogically or ignored. In responding to the event, we engage in making sense
of it, of producing a response (Holquist, 2002). As such, we are authoring the world and ourselves within that world, not as a freewheeling agent, but as a person with a history, with perspectives, language, and in an ongoing ‘flow of activity’ (Holquist, 1990, p.47). Dialogism:

Begins from social practice, emphasizes the existence of persons in time, attributes an open endedness to identity, attends in great detail to the distribution of the social in and over, and through persons, and insists upon the generativity of cultural genres through which people act upon themselves and others (Holquist, 1990 cited in Holland and Lave, 2000, p.9)

Bakhtin (1981) termed dialogue between the self and others as either ‘centripetal’ or ‘centrifugal’ orientations. Centripetal orientations are internalising perspectives through which the self draws meaning in and from external sources (Bebbington et al, 2007), whilst centrifugal orientations are externalising perspectives which the self transmits towards others (Kornberger et al, 2006), e.g. between the self and organisational structures (Garsten, 1999).

The professional self responds to others in a flow of conversation and discussion, and this can lead to a change in the understanding that others have of the professional self. This is because identity work is an effort of the self to project outwards to claim or affirm professional identities, to influence the course of events, the experiences with them and the externalisation of the knowledge, skill and value claims made by professionals through dialogic exchanges.

How we see ourselves and how others see us is the essence of a dialogic construction of the self (Cunliffe, 2002). Dialogical identities may be constituted within hybridisation, as the liminality that is present in boundary spanning could constitute a weaving together of perspectives and practices.

When professionals share their existence within an event in dialogue, not only with other human beings but with the natural and cultural configurations we lump together as ‘the world’, the world addresses them, and they respond; Holquist terms this ‘addressivity’ (Holquist, 2002, p.30). ‘We are responsible to the address of others and we are compelled to respond, we cannot
choose but give the world an answer.’ Bakhtin (1981, p.310) suggests existence is a kind of novel, or many novels; we each of us write our text, a text that is called our life. Bakhtin uses the literacy genre of the novel as an allegory for representing existence as the condition of authoring. ‘Heteroglossia’ is a term to signify language as ideologically saturated, a way of conceiving the world constituted by multiplicity of languages each with its own formal markers (Holquist, 2002). Perspectives are drawn from a myriad of available responses as signifiers of professional identities enacted in dialogue between participants and others through stories, where the medium of exchange is language. In such exchanges, it is words that fix meanings. Words can segment experiences into meaningful patterns; they exist to register sameness and difference (Goffman, 1959; Jenkins, 2008), and this study will be defined by my term ‘perspectives in use’, as ‘all words have the taste of a profession...’ (Bakhtin, 1981, p.280).

Dialogism is both a theory of knowing and an epistemology that ‘aims to understand human behaviour through the use humans make of language’ (Holquist, 2002, p.15 and p.18). The site of knowledge dialogism posits is not unitary and is in its essence hybrid (Holquist, 2002). At the heart of dialogue is the conviction that what is exchanged has meaning (Bakhtin, 1981, p.3). A dialogic encounter ‘is one where I can never have my own way completely and therefore I am plunged in to constant interception with others – and with myself’ (Holquist, 2002, p.39). Dialogism is based on the primacy of the social and the assumption that meaning is achieved by struggle. Existence is the event of co-being; in a vast web of interconnections in dialogue there is always more than one meaning. Dialogism therefore is the name for describing the ‘necessary multiplicity in human perception’ (Holquist, 2002, p.22).

‘The self is dialogic, it is a relation, dialogue can help us understand how other relationships work’ (Holquist, 2002, p.19). Meaning is relative in the sense that it occurs only because of the relationship between two bodies occupying simultaneous but different space. Dialogism means that reality is experienced, not just perceived, and that it is experienced from a
particular position. Dialogism is a theory that embraces multiplicity in human experiences, and is therefore a very relevant conceptual tool through which to examine complex professional roles and identities. It links to ‘perspectives in use’ and professional identities; as there is no single self, professionals do not have a singular voice visible in their perspectives. Voices as an expression of dialogue are produced in the discursive everyday practices of professional life, as Yancey (1994) argues:

For whatever kind of self we experience, it becomes within multiple contexts: the larger social structure, the local context, the personal. It relies on no single logic but on multilogic, expressed and created through multivocality (p.301).

Bakhtin’s concept of ‘transgredience’ reinterprets boundaries (De Peuter, 1998) as sites of the dialogical definition of self. Identity enactment becomes a continuing dialogue between real or imagined interlocutors, in which ‘the voice of others are equal partners in self dialogues’ (De Peuter, 1998, p.38) within the lived experience. This means that ‘the dialogical-narrative self is not a fixed text, but is a multitude of situated dialogic reinterpretations, reordered with each telling and hearing in changing social contexts’ (De Peuter, 1998, p.45).

The professional self is contextual, and called into dialogue during workplace interactions. This dialogue is generated and sustained through a network of workplace relationships. However, the shaping of dialogical exchanges is complex and dependent on authority, entailing the authority of knowledge, the willingness of others to listen and the power of being heard and attended to, i.e. is what is being exchanged through dialogue important to the professionality of those who are speaking and those who are being heard, the addressivity aspect of identity expressions that occur with dialogic exchanges, subject to revision and (re)negotiation. Dialogism posits that every individual is placed in a master dialogue of existence; that he or she is compelled by the structure of addressivity and that he or she is responsible for the activity of meaning in his or her local environment (Holquist, 2002, p.84).
Dialogism conceives the environment as a site of constant struggle between the chaos of events and the ordering ability of language; we discharge our responsibility by meaning making through authorial enterprise of translating life outside language into the patterns afforded by words, by narratives of various kinds.

For the HIP, I was interested in participants’ espoused professional identities, visible through participants’ stories and in workplace events. Within dialogism, all existence can be conceived as a series of events, the event of being responsible for and to the situation as it unfolds. In the unique and constantly changing place I occupy within it, some of the messages come to me through social codes, languages, ideologies, perspectives; I must respond by either ignoring them, or in a response that makes sense of them, producing meaning. I can make sense of the world by reducing the number of its meaning to a restricted set, linking to an individual’s professionality. ‘Addressivity’ means that meaning within the event is negotiated. Dialogism perceives the self/other relation in terms of different degrees each possess of the other’s otherness; this is hybridity. This is opposite to monologue. AMHPs’ stories will reveal how professional events structure themselves through dialogic exchanges.

### 4.5 Conceptual framework

Seeking to give meaning and explanation to AMHP professional identities as hybrid professionals requires a conceptual framework, and so six interrelated key concepts and the interrelated ideas within were deployed in the fieldwork design and analysis within the HIP as an educational lens for thinking, theorising, interpreting and discussing data (see chapter 5). This is summarised narratively (below) and then graphically in figure 4.6 as an overarching framework, with figure 4.7 summarising concepts of hybridity and figure 4.8 summarising...
concepts of dialogism. The rationale for the framework was to illuminate the important features, and the interrelationships that were likely to be of importance to the HIP (Robson, 2011, p.67).

Concept 1. Hybrid roles

I examined the roles that have been claimed in research that AMHPs enact (Quirk et al, 2000; Rapaport, 2006; Rapaport and Manthorpe, 2008). Additionally, as the context of practice has changed since this was last empirically researched, I enquired into whether there were additional roles that AMHPs enacted, and confirmed if previous roles were present within my sample; this built upon and extended Quirk’s et al’s (2000) research on ASW roles. My reading of Quirk et al’s (2000) work informed my thinking on hybrid roles, as his research found ASW occupied multifarious roles. Similarly, the work of Gregor (2010) and Morriss (2015a) was instrumental in my understanding of hybrid roles and in my exploration of hybrid roles within the HIP. When the MHA (Department of Health, 1983, 2007) extended the primary professional role of the ASW to AMHP, it sent a powerful message that social work was no longer the privileged occupation. When the role shifted from the Approved Social Work role to become part of a new AMHP multiple professional role, this involved new working practices for social workers, nurses and occupational therapists. As little is known about the how AMHPs enact hybrid roles and how this relates to hybrid professionals and identities, the HIP investigated the ways AMHPs drew on and claimed hybrid roles, and how their identity work was illuminated through this lens. Linking back to Quirk et al’s (2000) formative study of ASWs, where multiple roles were layered into the AMHP role, ‘hybrid roles’ was applied to examine both the roles illuminated from Quirk et al’s (2000)
study within my data and to investigate if there were new emergent roles that encroached on other professionals’ practice jurisdictions.

**Concept 2. Hybrid professionals**

Hybrid professionals occupy multiple roles, straddle professional and organisational boundaries, and have developed competence outside their main areas of expertise (Noordegraaf, 2007, 2015; Blomgren and Waks, 2015; McGivern et al, 2015). Hybrid professionalism is a negotiation of professional identity positions situated within dialogic exchanges as discursive expressions of professional practice. These are visible in knowledge claims that cross-cut areas of expertise and within multiple roles that AMHPs enact contextually. This concept draws significantly on AMHPs’ ‘perspectives in use’, as these have the capacity to reveal perspectives that were used in practice that cross-cut other professional jurisdictions and reveal the ways AMHPs could benefit from hybridity in the roles they enact to achieve desired outcomes. It incorporates understanding of what being a professional is, how it is practised, and how it is enacted dialogically through interprofessional working. It has the capacity to generate new empirical insights and could offer new knowledge of AMHP professional identities. I investigated the perspectives that AMHPs drew upon in their everyday work; I named these ‘perspectives in use’, to distinguish from other perspectives that participants may have in the professional repertoire of knowledge that is used contextually and selectively in their professional work. This is interrelated with centrifugal and centripetal orientations and heteroglossia (Bakhtin, 1981, 1990; Holquist, 2002). These perspectives are visible within the language used and the knowledge and value claims participants express in my data. Language illuminates hybridity, and I looked for examples through examining the perspectives participants used to externalise
their identity positions. Language positions participants as the same or as different to other professionals; through language participants position and are positioned in dialogical exchanges. ‘Perspectives in use’ constitute a working culture through which AMHPs situate their professional lens of practice. Additionally, a different way of conceptualising hybrid professionals was to view hybrid professionalism as a response to the uncertainties experienced in contemporary life, in risk societies (Evetts, 2006, 2013). Here I looked for examples of AMHPs’ ability to enable service users and carers to deal with risk through their use of expert knowledge across organisational and occupational arrangements (Noordegraaf, 2007). Hybridity is a relational concept, which requires ‘interdisciplinary knowledge and interactive skills’ (Noordegraaf, 2007, p.775). As such I looked within the data for examples of interactive skills, such as AMHPs’ ability to negotiate, facilitate and build rapport with other professionals during MHAA. Although hybrid professionalism connotes reflective practice, this element was not researched (Evans, 2013, p.482). Hybrid professionals are arguably adept at operating within ambiguous public domains that are not easily organised; as such, hybridity was considered as an everyday interactional achievement, where I aimed to investigate if AMHPs enacted their professional hybridity through their stories and if AMHPs benefited from types of hybridisation.

**Concept 3. Boundary spanning**

This concept encompasses key ideas concerning how AMHPs navigate and cross-cut other professionals’ jurisdictions, where interprofessional conflict is visible and/or where collaborative practice takes place. I explored connected and interconnected networks within this, including the organisation that AMHPs work for, the organisations they work across and the work that took place in private dwellings. The third space of hybridity, also referred to as
‘liminality’, does not co-occur in a nebulous zone but in dialogic exchanges, where other positions are enacted that differ from the officially sanctioned position. This is where AMHPs cross-cut into other professional jurisdictions of practice.

**Concept 4. Dialogism**

This concept is interrelated to concept 3, but differs in the sense that dialogism is *how* participants boundary cross into other professional jurisdictions. They do this through ‘dialogic exchanges’ with others, illuminated in the stories AMHPs tell which are characterised by a diversity of voices (Gunthner, 1998), hereafter termed ‘multivocality’ (Yancey, 1994), and a reflective retelling of events that have unfolded during Mental Health Act work. Such ‘dialogic exchanges’ position and reposition AMHPs’ professional identities. Here I will draw on centripetal and centrifugal concepts (Holquist, 2002) to illuminate the ways participants layer ‘different voices as speakers’ in the stories told, where other speakers’ voices e.g. police officers, psychiatrists in dialogic exchange amplify the ways AMHPs articulate both their role and identities. This was related to the sub-theme of ‘ironic dialogism’, where banter with the ‘other’ makes visible the constraints and improvisations that occur in the actions that participants navigate because of the ambiguities and complexities in ways of working within and between health and social care systems, often visible in the disjuncture between officially sanctioned practice and situated improvised practices. I investigated this idea through looking at examples of improvisation in practice encounters where participants conveyed how they improvised to achieve a desired outcome in their practice encounters with others. This included the concepts of negotiation and improvisation as sub-themes. For example, professionals often negotiate who should do what in certain marginal or new fields of activity in the workplace not formally regulated by the
state or the organisation (Wackerhausen, 2009). This is occurring in the identification of patient beds, a duty formally given to psychiatrists, administrated by bed managers, but then often negotiated between AMHPs and bed managers in terms of the suitability of the bed for the patient.

These ideas form the basis of looking at hybridity as an everyday interactional achievement. Through using these concepts for data analysis, my aim is to develop a new theoretical framework that will inform an understanding of AMHP professional identities as dialogic. Identities as they are enacted are dialogical at moments of listening and speaking. Identities are reflexive and dialogical as the view of others is essential for ‘authoring the self.’ When the self authors itself it is made knowable to significant others.

**Concept 5. Ironic dialogism**

Ideas of dialogism relate with ironies experienced in work contexts, because they constrain or enable the possibilities professionals have to recognise and create meaning through dialogic exchanges. Irony is a state of existence where opposing realities have separate meanings and definitions (Willis, 2000, p.177, in Holland and Lave, 2000); it is a lesson in dialogically navigating split epistemologies or perspectives. AMHPs are undergoing significant changes in the control of their working practices and conditions; more and more they are faced with contradictions between the work manual that is broken and a new rule book based on improvisation. There are multiple chaotic, informal and contradictory responses within AMHP practice to unfolding developments, such as those that happen during MHAA. This is where ‘ironic dialogism’ and AMHP stories of their professional identities could contain forms of irony (Willis, in Holland and Lave, 2000; Hoyle and Wallace, 2005). ‘Ironic
dialogism’ could be visible in ways of enacting practice dialogically, that are different from the officially sanctioned ways of everyday AMHP practice; they may be more dignified ways, more or less coercive ways, but are fundamentally ironic ways born out the disjunctures between officially sanctioned practice and situated practices. This idea links back to my discussion of the ‘ironies of adaptation’ and the ‘ironies of representation’ in chapter 3 (Hoyle and Wallace, 2007, p.1).

Concept 6. Social and professional identity theories

Professional identities are one form of social identity, and concern how individuals compare and differentiate themselves from individuals in different professional groups. Even though professional identities are socially constructed, they can be specified and empirically researched to understand the world. Concepts of professional sameness and difference were deployed within the HIP and will interlink with ideas of hybridisation enacted through hybrid roles and boundary spanning.

Social contexts are important, as identities do not exist independent of culture. AMHP professional identities are storied within professional practice; they are inscribed into AMHP subjectivities, and interaction is embedded in various social and cultural contexts. ‘Dialogic exchanges’ offer meaning and coherence, reflexively constructing professional identifications in a complex landscape of AMHP practice (Holquist, 2002). Identity construction is enacted in the relationships between an individual’s self-identity (who they are) and their social and professional identities (how they are seen by others in external institutions and other professional cultures) (Watson, 2009). The process of dialogue in this study concerns how AMHPs enact their professional identities through conversations/dialogue, where self-identity
is influenced and negotiated by social and professional identities (Watson, 2009). This is a process where the self constitutes and is constituted by professional work and the perspectives available to professionals and those they work with (Ybema et al., 2009).

The following figures were deployed as a diagrammatic representation of the concepts discussed. They provided conceptual guidance and were analytical tools that I employed to make conceptual distinctions and to organise my thinking and ideas. They further directed the collection and analysis of my data. They show the interrelationships of the key ideas deployed within the HIP. Figure 4.6 illustrates the overarching conceptual framework where, at the top of the diagram, I locate professional identities with dialogism, whilst at the bottom I locate the dimensionalities of hybridity with hybrid professionals.

**Figure 4.6 Overarching conceptual framework**

![Diagram showing the overarching conceptual framework with Hybridity at the center, dialogism and hybridity negotiated at the top, and hybrid roles, hybrid professionals, ironies, and perspectives at the bottom.](image-url)
Figure 4.7 Interrelated dimensions of hybridity

This diagram visually represents the dimensionalities of hybridity, through the dimensionalities of hybrid professionals, hybrid roles, boundary spanning and perspectives in use.
Figure 4.8 Interrelated dimensions of dialogic identities

This diagram presents the dimensionalities of dialogism and the potential links to ironies and dialogic identities.
4.9 Summary

In summary, hybridity is embedded in professional roles and identities that straddle boundaries of professional knowledge and practice, and occur in liminal spaces. It is a concept that confronts and problematises boundaries, although it does not erase them. As such, hybridity implies an unsettling of identities and alerts researchers to the difficulties of exploring cultural and professional differences in professional identities. This framework is an important heuristic device for exploring empirically the complicated professional entanglements and inter-professional relations of AMHP professional identities. Concepts of hybridity, boundary spanning, dialogism and irony are important concepts, because they have the potential to bring meanings and explanations to AMHP professional identities, in terms of the work AMHPs do with other professionals and their work within and across organisations. Therefore, figure 4.7 is deployed in chapter 6 to present case description of hybrid professional types from within the dataset, and figures 4.6, 4.7 and 4.8 are deployed in the overarching analysis of the dataset in chapter 7 and modified into a new conceptual framework regarding the key findings, contributions and implications of the HIP in figure 8.2 in chapter 8.
Chapter Five

Research Methodology

5.0 Research aims

The aim of the HIP was to investigate AMHPs as hybrid professionals negotiating dialogical identities. The discussion outlined in chapters 2 to 4 demonstrates the key issues and research problems regarding this matter, why fieldwork was needed, and why it has been conceptualised in this way through the conceptual framework presented in figure 4.6. This chapter outlines how the data collected to address these foci was gathered and analysed, and addresses matters of research design, ethical issues and relatability.

The HIP presents and uses a novel approach to hybridity within and for AMHP professional identities, and is structured through these research questions:

1. What is the role of the AMHP and how can AMHP professional identities be understood?
2. What is a hybrid professional and in what ways is it appropriate to conceptualise AMHPs as hybrid professionals?
3. What recommendations can be made regarding the use of hybrid professional roles and AMHP professional identities in the recruitment, training and practice development of AMHPs?

The research methodology is a case study of professional identities, situated in the stories of ten multi-professional AMHPs from social work, nurse and occupational therapy primary professional backgrounds, undertaken semi-longitudinally over a two year period from three
mental health trusts in England. Case study methodology was chosen for its approach to capturing complex phenomenon and the ‘rich and idiosyncratic features’ of AMHP professional identities (Yin, 2014). The semi-longitudinal approach adopted has benefits important for addressing the aims of the HIP; for example, the introduction of new legislation could be factored in as a potential influence on AMHPs’ professional identities, and changes to participants’ identities subject to other influences could be incorporated. This is important for gaining insight into the under researched area of AMHPs’ professional identities. The semi-longitudinal approach taken allowed participants to be returned to acting as a form of participant and researcher validation (Cohen, Mannion and Morrison, 2011), where clarification could be gained on researcher interpretation and participation. Investigating AMHPs’ professional roles and identities semi-longitudinally is important to gain an in-depth and detailed insight into the enactment of professional roles and identities in relation to cultural, organisational contexts and socio-political influences (Denzin and Lincoln, 2006; Denscombe, 2010). Research investigating professional roles and identities needs to be sufficiently dynamic to account for potential changes over time. The rationale for a case study included the proposition that as roles and identities are socially constructed, they are influenced by wider contexts and subject to change.

The HIP is located within a social constructivist epistemology, and drew on symbolic interactionism (Goffman, 1959; Crotty, 2015). Within symbolic interactionism, reality is enacted within social interactions with others, whilst constructivism within a post-modern context stresses the ongoing development of a multitude of world views enacted by individuals in their dialogical interactions with others. Theories of the social identity, applied within the HIP’s conceptual framework, can broadly be classified as belonging to an ‘interactionist’ tradition (Crotty, 2015), where identities enacted in social contexts hold
meanings for professionals, individuals, organisations and wider society. Symbolic interactionism addresses the subjective meanings people impose on events. Subjective meanings are given primacy, and identities are socially constructed. My position is that there are multiple realities that are construed within interaction between human beings and their world, developed and transmitted dialogically through symbolic communication within social contexts. Individuals and groups use symbols, especially language, to name, categorise, perceive, think, consider, remember, create new ideas and solve problems. Symbolic communication provides a means of defining the present according to a perspective or construction developed and adapted within and through social interactions (Giddens, 1979; Blaikie, 1993). The social constructivist epistemology helps me to deliver on the HIP’s aims through addressing the research questions by locating professional identities as socially constructed and enacted. I acknowledge that my interpretation of professional roles and identities is culturally and historically located.

5.1 Case study

Case study is an empirical inquiry that ‘investigates a contemporary phenomenon within its real-life context especially when the boundaries between the phenomenon and context are not clear’ (Yin, 2014, p.16). It is an examination of a specific event, organisation or system that presents detailed data of complex human phenomenon. Case studies are the preferred strategy when how or why questions are being posed, when the researcher has little control over events, and when the focus is on contemporary events (Yin, 2014). They represent:

a strategy for doing research which involves an empirical investigation of a contemporary phenomenon within its real life context using multiple sources of evidence (Robson, 2002 p.178).
A case study methodology was chosen to capture the holistic and meaningful characteristics of real life event(s) (Yin, 2014). It is appropriate for generating data on professional identities and the context of professional identity enactment in ‘organisations, teams, the workplace.’ It is a suitable methodology for investigating professional identities.

Widely used and variously defined, case study can have as its object of study an individual, a group, an institution, or wider reference, with importance placed on defining the borders of the case (Chadderton and Torrance, 2011). Case study is an intense study of the particular and does not aim to make broad population or statistical generalisations. The purpose of the case study is not to represent the world but to represent the case (Bassey, 2001; Stake, 2003). The specified boundary of the ‘case’ is the participants’ professional qualification and current practice as AMHPs.

One of the purposes of my case study was to expand and generate theoretical perspectives, through ‘analytical generalisation’ to reveal a new understanding of hybridity and dialogical identities (Yin, 2014). The case of professional identities is ‘contextual, local and situated – as are all narratives – cases integrate what otherwise remains separated’ (Shulman, 2014, p.28). This is an important point as professional identities may be dissected into distinctive parts or features within some research methodologies, thus fracturing the participants’ data into a sum of parts, rather than an integrated whole. However, case study enables me to represent the case of professional identities in context, so that complexity, nuance and narratives are illuminated.
5.2 Conceptualising the study

My study was designed with a conceptual framework (figures 4.6-4.8) deployed as a lens to bring new insights and explanations of AMHP roles, identities and hybridisation. This has evolved and was refined through my fieldwork, analysis and review of literature as previously discussed in chapters 2, 3 and 4, leading to the final overarching framework presented in figure 8.1 (Cohen et al, 2011; Mason, 2014). It served as a dynamic ‘superstructure’ for the HIP (Macfarlane and O’Reilly, 2012; Ravitch and Riggan, 2012), supported my intellectual and methodological focus, and guided my research design. As such, it was deployed as a set of lenses for making sense of AMHP professional identities. My conceptual framework usefully incorporated different yet interrelated aspects of my project, and was used to provide important insights that arguably produced a deeper understanding of the case than a single theoretical perspective could provide. The conceptual framework was integrated across the various stages of the HIP, interlinking what was learnt from my fieldwork into my conceptual framework into my overall understanding of the topic and the presentation of my findings.

Three separate but interrelated topic based interviews were designed to excavate data on the key concepts within the framework to address the research questions. I conducted these at approximately seven monthly intervals over a period of two years. I named these stage one, two and three interviews (see Appendix A, B, C and D). At stage one, I investigated participants’ professional relationships with other professionals they worked with during MHAA, participants’ espoused professional perspectives and roles enacted in practice, and participants’ espoused knowledge, skills and values. I investigated inter-professional conflicts, tensions and collaboration as possible ways of participants externalising sameness.
and difference to other professionals’ practices and ‘perspectives in use’. This was related to my conceptual framework in relation to social and professional identity concepts, my concept of ‘perspectives in use’ hybrid roles, and identities and boundary spanning. At stage 2, I focused on links between personal and professional identities by asking participants what had influenced them to become AMHPs to understand possible links between social and professional identities, relating to social and professional identity concepts and influences on professional identities. At stage 3, I used interviews to investigate concepts of dialogism and irony by asking questions about how participants improvised to achieve desired outcomes in their practice encounters with other professionals during MHAA through enacted roles. The details of the interviews are discussed fully in section 5.6.

5.3 Choosing a sample

Ten AMHPs were purposively selected from three Mental Health and Social Care Trust sites comprising 7 social workers, 2 nurses and 1 occupational therapist of varied professional service locations, age, gender, ethnicity and occupying several roles (Denscombe, 2010). Prior research indicated that the population of trainee AMHPs comprised 84% from the social work profession, 15% from the nursing profession, and 1% from occupational therapists; no psychologists had qualified (General Social Care Council, 2012, see Appendix V for a detailed breakdown). Figures obtained from 120 of 152 councils in England through Freedom of Information requests by Community Care indicated that the number of AMHPs fell by 7% from 3,139 to 2,915, although this figure does not include AMHPs practising in Wales or the percentages of social workers, nurses or occupational therapists (Community Care, 2016). A sample size of 10 was considered appropriate to generate in-depth data and to assist with my research aim of investigating multi-professional AMHP identities. This was a sample size
that ensured both enough data (sampling adequacy) and, by interviewing participants who had experiences of the phenomena under exploration (i.e. their professional identities), the sample was appropriate (Robson, 2011; Silverman, 2013). In the HIP 70% were from social work, 20% from nurse and 10% from occupational therapy primary professional backgrounds.

Pseudonyms were given to protect the identities of participants. Table 1 below shows details of the demographic characteristics of each AMHP. The sample size was considered using the advice of Doucet (2006), who encouraged researchers to become familiar with their epistemic communities, to answer the question of ‘how many’ is enough to satisfy markers, mentors, peers, readers and the epistemic community, as well as publishers’ criteria for numbers within qualitative research for research to be published. The sample needed to be of a sufficient number to illuminate the aims and research questions, but manageable within limited time constraints for conducting small scale research (Baker and Edwards, 2012; Bryman, 2012, p.425). Ten was a suitable sample for qualitative research (Baker and Edwards, 2012; Bryman, 2012, p.425). As I interviewed each participant three times, the small number enabled rich data and interpretations to be derived, balanced against practicalities and timescale as a doctoral researcher.
Table 1: Demographic characteristics of study participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Professional background</th>
<th>Role/Workplace</th>
<th>No. years in AMHP practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth</td>
<td>social worker</td>
<td>care coordinator, best interest assessor, adult community mental health team</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 1</td>
<td></td>
</tr>
<tr>
<td>Dawn</td>
<td>occupational therapist</td>
<td>care coordinator, community mental health homeless team</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 1</td>
<td></td>
</tr>
<tr>
<td>Kate</td>
<td>social worker</td>
<td>care coordinator, best interest assessor, later life community mental health</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>team site 2</td>
<td></td>
</tr>
<tr>
<td>Simon</td>
<td>nurse</td>
<td>care coordinator, deputy manager, community mental health team</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 1</td>
<td></td>
</tr>
<tr>
<td>Tina</td>
<td>social worker</td>
<td>senior social worker, care coordinator, mental health city wide service</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 2</td>
<td></td>
</tr>
<tr>
<td>Matthew</td>
<td>nurse</td>
<td>care coordinator, deputy manager, crisis home treatment team</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 3</td>
<td></td>
</tr>
<tr>
<td>Diana</td>
<td>social worker</td>
<td>senior mental health social worker, care coordinator, mental health city wide</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>service site 2</td>
<td></td>
</tr>
<tr>
<td>Bernie</td>
<td>social worker</td>
<td>senior mental health practitioner, care coordinator, mental health city wide</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>service site 2</td>
<td></td>
</tr>
<tr>
<td>William</td>
<td>social worker</td>
<td>care coordinator, best interest assessor, early intervention team</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 3</td>
<td></td>
</tr>
<tr>
<td>Annette</td>
<td>social worker</td>
<td>local authority commissioner</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>site 3</td>
<td></td>
</tr>
</tbody>
</table>

I recruited by email based on previous working relationships either as ex-students from the AMHP course (these were Simon, Dawn, Elizabeth, Annette, William, Bernie) or previous working colleagues (Tina, Diana, and Kate) (See Appendix T- email to participants).

Matthew asked if he could be a participant following a presentation I delivered at his trust. It
was important that I had some prior knowledge of the professionals I recruited as I needed to access ‘knowledgeable people’, who had experience in the role and who could talk in detail about their knowledge, skills and values, and the influences on their professional identities (the impact of this is discussed in section 5.10). As Denzin and Lincoln (1994) (cited in Silverman, 2014, p.202) add, many qualitative researchers ‘seek out groups, settings and individuals where…the processes being studied are the most likely to occur.’

5.4 Methods

I used several data collection methods: face to face semi-structured topic based interviews, a visual concept mapping method where participants wrote down the influences on their career on a white board, a demographic questionnaire via email (See Appendices A, B, C, D, E and U), and researched literature in the fields of mental health policy and practice, professional roles, identities, hybridity and dialogism.

Face-to-face semi-structured interviews

Given my research aims and objectives, semi-structured interviews were appropriate methods of qualitative of data collection (Denzin and Lincoln, 2006; Denscombe, 2010; Mason, 2014; Silverman, 2014), through which I gathered a plethora of data about professional roles and identities. Highly structured interviews were inappropriate because they are inflexible and would not yield responses to emergent themes anticipated in the under researched area of AMHP professional identities.
I accessed participants’ espoused professional identities within a constructivist epistemology. The approach offered pragmatic answers to ‘how’ questions in my study (Silverman 2013; Silverman, 2014). Each stage of interviews had specific (see Appendices A, B, C, and D) areas of the research questions to investigate but was flexible in terms of the order I asked the questions. In conducting the interviews, I utilised prompts that allowed further detail to be gathered, clarification to be given and elaboration of key themes to be facilitated to gain rich data. The details of the three interview stages are now reported in full below.

**Interviews Stage One (October 14 – December 2014)**

The first interviews were face-to-face semi-structured interviews based on the following topic areas: AMHP knowledge, skills and values; working relationships with other professionals, such as psychiatrists, police officers, ambulance personnel and other AMHPs (see Appendix A-Topic Guide Stage One). The questions were themed around how AMHPs work with each other and how they work with other professionals. Within this theme, I explored the type of work AMHPs did, the professional knowledge, skills and values they claimed, the conflicts and tensions experienced in their relationships with other professionals such as police officers, doctors and ambulance personnel, and the services they experienced tensions and conflict with, such as crisis home treatment teams. This theme was drawn from concepts of professional socialisation and identities. I explored the perspectives AMHPs enacted in their daily working practices, e.g. social perspectives or medical perspectives of mental distress, and ideas concerning shared professional culture with fellow AMHPs in the service, including ideas of shared professional culture, consisting of knowledge, skills and values, that influence and shape professional identity (Abbott, 1988; Barnes *et al.*, 2000; Gee 2000; Tajfel and Turner, 2001; Noordegraaf, 2007; Allen, 2014; Watson, 2016; Webb, 2017). The
interview guide linked to research questions one and two.

I then analysed the data from all ten participants’ interviews over a period of one month following completion of this stage of fieldwork, to gain a sense of the depth and diversity by listening to audio recordings, reading and re-reading transcripts and making observational notes to begin the process of bringing meaning and conceptualisation to my research questions. I took notes during and after interviews, noting early emergent themes. I transcribed all the interviews, and produced a summary of each interview to highlight the major themes. These summaries were considered alongside the transcripts, where I highlighted significant portions of text, and colour coded using concepts from the first iteration of my conceptual framework (See Appendix I-First iteration of conceptual codes).

**Interviews Stage 2 (April 15 – July 15)**

I returned to the same participants between April and July 2015 to explore my second theme of professional identities (See Topic Guide Stage Two-Appendix B). This theme concerned influences on identities (Davies, 2003; Evans *et al*, 2005; Billot, 2010; Beddoe, 2011; Craig *et al*, 2013; Watson, 2016; Webb, 2016; 2017). I started the interviews by asking participants to complete a career map, derived from the work of Ausubel (1963) (See Figure 2 for an example), of their influences on career. I asked participants to write down on a whiteboard influences on their professional identities. I requested they wrote their most important influences in the centre of the diagram and then worked out to the diagram’s periphery to the influences that had less importance to them. The career map activity was designed to stimulate participants’ deep thought on their influences on their career. The interview was introduced by showing a map I had populated myself (although they did not know this
example was my own, as I did not want to influence them). I stated that their career map may have similar features or may be quite different, and that I was really interested in anything they thought had influenced their career up to the point of the interview. I then asked if they had any questions or needed any clarification, and following that I left them for approximately fifteen minutes to populate the map. This gave participants time to think individually and to reflect upon the influences most important to them. Using a whiteboard gave the participants chance to erase and move things around as they worked through their thoughts. As soon as the participants finished the map, I re-entered the room and used their maps to talk about what they felt had influenced their career and professional identities.

In using concept mapping I was asking participants to root the influences on their professional identities in something specific and tangible. In asking them to tell me about what had influenced their espoused identities I was using ideas to explore the potential links between participants’ personal identities (Goffman, 1959; Tajfel and Turner, 2001; Smith and Sparkes, 2008) and professional identities (Billot, 2010; Beddoe, 2011; Leah, 2013; Morriss, 2015a; Webb, 2016, 2017). Similar influences were noted across the sample but, as expected in exploring identities, there were individualities. Concept mapping was used in several ways to explore complex phenomena and was a useful relational and visual data gathering method. The map encouraged participants to convey influences that they considered important to them and the map was a valid visual method. The combination of drawing maps and talking about influences on professional identities produced interesting data and highlighted participants’ complex interrelated personal and professional experiences, facilitating the expression and externalisation of espoused influences on professional roles and identities (White and Gunstone, 1992).
Following the concept map interview, I conducted face-to-face semi-structured interviews, asking participants to tell me their stories of why and how they became an AMHP. This was open-ended and I encouraged participants to talk in their own way. Some rooted this story chronologically, whilst others identified key people, educational achievements and influences as part of their career stories. The interviews aimed to explore the links between certain influences on their career and how professional identities are storied and enacted. I then analysed the data from all ten participants’ interviews as described earlier over a period of two months following completion of this stage of fieldwork. Both the concept map text (see Figure 2) and interviews were used as units of analysis. The images were photographed, turning the images into a text and image combination that was available as a unit of analysis. I then entered all the words from each participant’s career map into a table for analysis (see Appendix H-Extract of Influences on Career). The map and its descriptive text were coded and analysed.

**Figure 2. Illustration of a career map from Matthew, Interview 2**
**Interviews Stage 3 (October 2015 – December 2015)**

Between October and December 2015, I conducted face-to-face semi-structured interviews investigating ideas of hybridity (Walter, 2003; Noordegraaf, 2007, 2015; Croft *et al.*, 2015; Waring, 2015; Spyridonidis *et al.*, 2015; Solomon *et al.*, 2016) (See Topic Guide Stage Three-Appendix C). Ideas centred on whether non-traditional AMHPs, such as nurses and occupational therapists, had become adept at operating within the discursive practices of social work AMHPs, the major primary professional group, or whether a more fundamental reconfiguration of professional practice was leading to the emergence of a ‘hybrid professional type’ (Tate, 2000a, 2000b; Walter, 2003; Warrington *et al.*, 2004; Noordegraaf, 2007, 2015; Waring and Currie, 2009; Spyridonidis *et al.*, 2015; Waring, 2015; Solomon *et al.*, 2016). For example, during the reform of the Mental Health Act it was stipulated that AMHPs would hold a social perspective (Tyrer and Sternberg, 1987; Tew, 2005, 2011; Rapaport, 2006; AMHP Regulations, 2008; Rapaport and Manthorpe, 2008). In this way, the social perspective, previously a jurisdictional claim of the social work profession, became a jurisdictional claim for all AMHPs. This is a training and practice requirement that must be met by other qualifying professionals wishing to ‘encroach’ on this area of work. The perspectives enacted by participants were explored in detail. Additionally, hybrid roles emerged as a feature in my pilot study, where participants talked, for example, about ‘acting’ as judges, weighing up the case to arrive at a ‘judgement’, and have emerged in other literatures on AMHP roles, but not as a feature of professional identities (Quirk *et al.*, 2000; Rapaport, 2006). In previous research, as discussed in chapter 3, ASWs occupied multifarious roles (Quirk *et al.*, 2000), where the nature of the ASW role suggested several different ‘hats’ that ASWs would wear, depending on the nature of the Mental Health Act Assessment. One of the aims of the method was to interrogate the idea of AMHPs enacting
‘hybrid’ roles, working within broad knowledge areas and with competence outside of their main areas of expertise, as one way of accessing professional identities, allowing participants the opportunity to talk about what it meant to them individually to be an AMHP. This linked with ideas about how and to what extent the hybrid nature of the AMHP role impacted upon primary professional identities. As the AMHP role was a new and emerging professional role, it was important to explore new and emerging concepts of professional identities, and hybridity was an important conceptual lens by which to do this.

In the interviews, I invited participants to talk about the ways in which their work was similar and dissimilar to other professionals’, drawing on Goffman’s (1959) in and out-groups and Jenkin’s (2006) sameness and difference concepts, and asked them to illustrate how they straddled different professional boundaries and jurisdictions, linking in with ideas of boundary spanning. The professionals chosen were based on the researching findings of Quirk et al (2000) and Rapaport (2006). The professionals I used were lawyers, psychiatrists, general practitioners, police officers and therapists. Additionally, participants were invited to discuss other professional roles they thought they were like, and to give examples of similarities and differences. I used this data to investigate how participants straddled different professional boundaries, roles and jurisdictions of professional practice.

Following data analysis of interviews, I designed a small questionnaire, distributed individually by email, to gather brief background data on participants’ demographic features, their age, ethnicity, gender, length of time in practice as an AMHP, the teams they worked for and the professional composition of those teams. The resultant dataset consisted of transcribed interviews from the three stages and brief demographic data on all 10 participants from an email questionnaire (Appendix U), and a table of hybrid types (Appendix W).
5.5 Data analysis

Several reference sources were consulted that offer models for coding and interpreting data. ‘Framework Analysis’ was chosen as it indicated a systematic analytical process, with five distinct interconnected stages of ‘familiarisation’, ‘identifying a thematic framework’, ‘indexing’, ‘charting’, and ‘mapping and interpretation.’ Drawing on ‘Framework Analysis’ (Richie and Spencer, 1994), I analysed data from all ten participants’ interviews over a period of one month following fieldwork completion in stage one, to gain a sense of the depth and diversity by listening to the audio recordings, reading and re-reading transcripts, making observational notes to begin the process of bringing meaning and conceptualisation to my research questions. I transcribed all the interviews, highlighting significant portions of text, colour coding from the concepts derived from the first iteration of my conceptual framework (Appendix I). I had by now produced a data set from interviews at stage one that were coded. I then considered how the data set as a whole spoke to my research questions. I did this by looking within each participant’s data set and made extended notes. Here I moved between data and theorisations, using induction and deduction to explain data in relation to the first iteration of my conceptual framework (Appendix I). I repeated this process for stage two interviews and produced a second iteration of my conceptual framework (Appendix J), used for coding and analysing the data set comprising of the individually coded face-to-face interviews and the concept map, and again considered how the data spoke to the research questions.

At stage three I repeated this process and then looked across the whole of the data set, first by all participants together at each stage, considering in turn data from all participants from stage one, stage two and stage three interviews collectively, then within individual
participant’s data sets through the three stages. As I went along, I refined my conceptual framework (Appendix K). Here I used theoretical perspectives about professional roles and identities, hybrid professionals, hybrid professionalism, boundary spanning and dialogism, recoding and reanalysing data to produce a final dataset, using comparative tables and coding to display, compare, and show patterns and connections between data, looking for replication of features across participants and areas of divergence and individualities.

I then ‘lifted’ data from its original context and rearranged it according to the appropriate conceptual code, to build up a picture of the data considering each concept and the interrelationships. I colour coded using Microsoft word, using the highlight function and distinguished codes by colour, capitalising, bolding, bulletining, underlining and italicising text, using track changes to make observational notes and comments (Condie, date of access, 02.09.2012; Hahn, 2008). Themes was continually reworked until a theoretical explanation of the phenomenon under study offered a theoretical explanation of professional role(s) and identities, boundary spanning, hybridity and dialogism. In doing so, I was looking to define the elements of professional roles and identities and to determine the range of and nature of these elements. I defined participants as hybrid types by searching through the data for their perspectives in use. I then coded the data and grouped participants by their most dominant perspectives in use, ranked by the occurrence and emphasis within the data to arrive at hybrid types (see Appendix W). Thematic material was identified and categorised in relation to answering the research questions, producing the findings presented in chapter 6 on ‘perspectives in use’, hybrid roles, and boundary spanning (see Appendix O-Exemplar narratives of hybridity) and chapter 7 on enacting hybridity through dialogic identities.

This was a dynamic process, since before the interviews were undertaken there was a
knowledge of professional identities and hybridity. As themes started to emerge, literature was again consulted to make sense of emergent themes, so that the relationship between themes and literature was cyclical. As new concepts emerged these were interrogated throughout the data set to generate ‘theoretical sensitivity’ (Stake, 2003; Silverman, 2014; Yin, 2014). This ensured that any important findings were not missed. The analytical approach involved carefully drawing on my conceptual framework. Essentially, themes were illuminated as events ‘to show how participants saw themselves’ and how they enacted professional role(s) and identities through their espoused narratives (Tate, 2007). These events were interpreted as selective representations of participants’ experiences that illuminated their professional roles and identities at a given point in time and context. Events were interpretative but also required interpretation, and in these acts of interpretation I aimed to produce new empirical meanings. Data will be presented with key quotations from participants’ narratives in the following chapters to bring meaning and explanation to the research questions. In the sense of making analytical generalisations, this was based on both corroborating and advancing theoretical constructs of professional role(s) and identities and in terms of illustrating new concepts that arose from the data. These a priori theoretical propositions assisted greatly with analytic generalisations, in the sense of going beyond the particulars of analysing individual AMHP’s narratives to learning something that could be analytically generalised to AMHPs as a professional group. New concepts emerged from my research; these are ‘perspectives in use’ and ‘ironic dialogism’, discussed in chapters 6 and 7. The interplay of conceptual tools and data produced new explanations, discussed in chapter 8 as a contribution to knowledge.
5.6 Ethical approval, access and location of the research site

Ethical approval was gained from the University of Manchester Ethics Committee, which classified the study as medium risk (PGR-73612820), with additional research and design approval from three trust sites based in the North West of England where participants were employed. (This was in conjunction with University sponsorship and indemnity letters (Study Reference 14/25) (Appendix S-Ethical Approvals).

I recruited via heads of social care (gatekeepers) and contacted participants by email once approval was authorised by ADASS and NHS trust ethical approval committees (ADASS Research Group Guidelines, n.d.-a; Research Governance Framework, date of access, 12.07.2014). I had good working relationship with three heads of social care from my role as a lecturer and used these relationships to assist in the recruitment of participants. It was the organisations’ policy and procedure that if participants used work time for research interviews that gatekeeper approval would be required. This created a potential dilemma in my recruitment process around matters of participant anonymity and confidentiality. Using gatekeepers potentially meant that the participants could be known. However, I agreed with the gatekeepers that they did not request participants’ names. If participants were asked to provide details of the research project by their team managers, they could advise their team managers to contact gatekeepers. Gatekeepers agreed to advise team managers if they were approached of my study details and that permission had been granted to release participants in work time. When I checked the process with my participants they all reported that their team managers did not ask them for details of the research project; therefore, anonymity and confidentiality was maintained. A condition of approval was dissemination of my research findings at local AMHP forums.
I discussed with participants their rights to confidentiality and anonymity, giving details of involvement and advice about withdrawing without question from the study at any time (Appendix E-Participant Information Sheet). Signed agreement was obtained, allowing dissemination in published peer reviewed journal articles and at conferences (Appendix F), where pseudonyms would be used and mental health trusts’ names and geographical locations anonymised.

Data was encrypted and stored in a secure cabinet on a password protected computer at my employing university. Participants were given pseudonyms and anonymized workplaces and agreed (along with gatekeepers’ permission) to use work time for the interviews. This was as much as ten hours over the course of the study for some, including correspondence, travelling and interview time, so was not inconsiderable.

Interviews were conducted face-to-face at workplaces (n-7), the university (n-2) or one participant’s own home (n-1) to reduce the burden on those participating in work time, ensuring minimum disruption to their working day and freedom from the interruptions of the workplace. This enabled participants to organise the interview context in ways that suited them best (Hammersley and Atkinson, 2007). The request to be interviewed at home came from Elizabeth. She had a routine of going home in her lunch hour and said this was more convenient. There were no ethical issues identified; I was not at risk as it was only ourselves present for interview in her home. However, contact details of my location, date and time were left with my manager (UoM Research Ethics, Date of Access, 16.01.14). I was fortunate that all ten participants remained in the study and I did not lose any to attrition.
At the start of each interview, I restated procedures for preserving participant anonymity and confidentiality, asking them to sign the consent form before the interview began. Ethical approval for interviews had been granted for up to ninety minutes in length. The actual length varied from 25 minutes to 90 minutes. As part of a relational approach to ethical approval, participants were again asked at the end of the interview if there was anything they wanted to change or exclude (Chew-Graham et al., 2002).

My position as a lecturer was one that my participants trusted. They were aware that I had a professional code of ethics and of my ethical responsibilities as a researcher to provide a trustworthy and ethically sound study. The prolonged engagement over two years with participants permitted the development of a trusting relationship (Robson, 2011). Retaining the trust of participants meant not compelling them to undertake anything that would make them feel uncomfortable, and that no one felt coerced or obliged to participate in my research. In response to issues of insider research as a previous ASW and educator of AMHPs, I reassured participants that it was not the intention to judge their practice or hold them accountable in any way for views expressed; however, I advised of my duty to report to the regulatory body areas of illegal practice (HCPC, SCPE, date of access, 08.03.2012).

Ensuring tolerance and being non-judgemental was crucial to enable participants to feel at ease and encouraged an open dialogue, as all research must adhere to being non-judgmental and treat participants with utmost respect (Berger, 2013; Silverman, 2014). The emerging findings were discussed with my supervisor and with two academic peers, who offered constructive criticism, thereby acting as a critical friend and an external check on ethical issues. I presented initial findings at four conferences (JSWEC, 2015, 2016; PGR Conference, 2015 and QSW, 2015).
5.7 Contesting Identities

Identities should not be taken for granted, and how one perceives the identity/ies another person enacts must be treated cautiously; for example, not all aspects of a person’s identity/ies may be visible to those doing the external perceiving. Furthermore, the perceiver’s assumptions of how an individual embodies or enacts their identity/ies, i.e. as a mother, a football fan, professional etc. and the significance attached by the perceiver of such judgements must be made explicit within any research project. This means I cannot interpret a professional’s identity/ies from limited information and that in attempting to research AMHPs’ professional identities, I make explicit that each participant had a unique biography, the full extent of which was not accessed within the foci of my research project. Therefore, I have made inferences regarding the nature of participants’ professional identities based upon my epistemological positioning as a social constructivist, through my conceptual framework and within my data analysis. I have investigated professional identities through a constructivist lens, at a given point in time, within a particular context. In conceptualising professional(s) identities, I acknowledge identity is a dynamic and fluid phenomenon that can be influenced by cultural backgrounds (including workplace and professional cultures) to varying extents, can change over time and is complex. Giddens (1991) argues that identities are actively shaped by a person, who reflects upon who they are, and in doing so crafts his or her biographical narrative. As previously discussed, it ‘involves a subjective interpretation of our individuality in the context of activities’ (Billot, 2010, p.3). This means identity/ies are a reflexive project, where a person keeps a narrative going about who they are. My research has accessed participants’ narratives by asking participants; ‘What is your professional identity/ies?’ and through using participants’ narratives from interviews in chapter 6 of how they perceive their identities. I have subsequently made inferences in relation to dialogical
identities from the data gathered, through drawing on my conceptual framework, discussed in chapter 6.

5.8 Interviewing peers, considerations of insider research, positionality and reflexivity

Research involving professional peers creates methodological issues. There are both advantages and disadvantages, since, unlike with traditional interviews, the interviewer and interviewee are known to each other. Shared professional membership was helpful, as peer researchers can evoke perceptions of solidarity and cooperation, encouraging confidence and sharing of potentially richer stories (Chew-Graham et al., 2002; Coar and Sim, 2006; Leigh, 2014). This shared interest and knowledge can increase interviewers’ credibility (Andersson et al., 2001; Coar and Sim, 2006). The role of insider did offer certain advantages; in studying the familiar I knew about the topic and could understand the nuances conveyed, including professional language that was abbreviated, e.g. ‘sectioned’, ‘CTO’ etc. However, I was careful that the benefits of position and familiarity did not blur boundaries too much (as some blurring is inevitable in human interactions), and was careful to recognise the imposition of my values, beliefs and perceptions onto the interview process.

Insider status affected my access to the field, as participants were willing to share experiences with me as an ‘insider and/or ex-colleague and lecturer’. In terms of insider perspectives, I recognised myself and was recognised by the participants as being part of a professional group, but I did not feel a fully-fledged member, as there were changes to the ways participants talked about issues important to them that were unfamiliar to me. Shaw eloquently describes this as: ‘Simultaneously being an onlooker in the stalls and a member of the cast’ (Shaw, 1996, p.10). One example was when I asked participants about their values, I
sensed they felt ‘tested’ and I had trouble eliciting a depth of response in this interview. To overcome this barrier, I used stage three interviews to draw out the values I had trouble accessing in stage one due to this over-familiarity or feeling of being ‘tested’. This led to my recognition that all researchers of qualitative phenomena must balance their own experience, which can offer important insights and a deeper understanding of the phenomena, whilst at the same time declare and reflect upon the inevitable bias that their experiences, beliefs and values could have on participants (Pillow, 2003).

Several issues arose within the interview encounter: a perception by some participants (Diana, Simon) that the interview was a test, indicated by comments such as ‘I hope I’ve answered your question alright’, and some interviews having elements of a pseudo-educational process, indicated by Diana asking my view of whether a MHA assessment was illegal, treating me as both colleague, interviewer and expert resource. Humphrey (2012) proposed that researchers occupy multiple roles within the interview encounter. In my study, I found I was managing a combination of roles: researcher, ex-colleague, ex-lecturer, social worker and mental health professional.

An issue that arose from using interviews was interviewer effect. In any interview situation, there is a range of implicit and explicit social clues that can lead both the interviewer and interviewee to determine what the researcher’s preferences and biases may be. This is termed researcher bias (Drake, 2010; Humphrey, 2013), with some scholars suggesting that ‘all interviews are jointly constructed by all parties’ (Freebody, 2003, p.132; Humphrey, 2013). I was aware when interviewing peers of the effects of social desirability (Platt, 1981). This was addressed through a reflexive approach, where I used my professional knowledge to pose questions and interpret answers. Reflexivity was an important strategy to employ in
generating knowledge through qualitative research (D’Cruz et al, 2007). The creation of knowledge shaped the beliefs, biases, and how professional backgrounds and personal experiences impacted on the research. Reflexivity was a process of continual internal dialogue and critical self-evaluation of my positionality, as well as the active acknowledgment and explicit recognition that my position may affect the research process and outcome (Platt, 1981; Stronack et al, 2007; Berger, 2015). My reflexive approach involved opening my researcher ‘lens’ to critical scrutiny and reflectively considering the effect it was having on me and on my participants. I gained rich insights by capitalising on a shared professional culture as well as collegiality.

As a researcher, I was influenced by the social world I was researching. As a previous Approved Social Worker (the role prior the AMHP role) and lecturer on an AMHP professional programme, I brought my own understanding of the role, of what good practice consisted of and of the major areas of knowledge, skills and underlying values that AMHPs should operationalise as part of their role. As such, this was not a neutral enquiry, and was influenced by my prior views of the role, and my epistemological and ontological positioning. At times reflexivity was a conscious and deliberate effort to make the familiar strange with some participants’ responses being surprising. Ultimately, my understanding of professional roles and identities is neither better nor worse as an insider; it was the approach of my study and was intimately connected to my positionality and positioning within the interviews. To omit these observations and edit out sections that painted a not-so-rosy portrait would only serve to delimit understandings of relational life and obscure the materiality of everyday professional roles and identities.
5.9 Relatability

The HIP contributes towards theoretical perspectives of hybrid professionals and dialogic identities that can be applied to wider populations of AMHPs, contributing to empirical knowledge through analytic generalisations (Yin, 2014). Specifically, my research proposes that AMHPs are hybrid professionals and that their hybridisation is illuminated within the concept of espoused dialogical professional identities. I discussed within this chapter previously the process of theorising involving balancing the tensions of an inductive and deductive approach when analysing data. The balance between an inductive and deductive approach is an important aspect of the theorising pertinent to the trustworthiness and credibility of a case study approach (Yin, 2014). Lincoln and Guba (1985, p.290) highlight the importance of trustworthiness in conducting research, stating:

The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audience (including self) that the findings of an enquiry are worth paying attention to, worth taking account of?

In consideration of the credibility of a case study methodology, Bassey’s (1983, 2001) work on relatability is a useful concept to employ. The idea of relatability in research is that professionals can judge the credibility of research for themselves. When professionals read research, Bassey (1983, 2001) argues if they can relate to it, in the sense of using it to develop their own understanding of their professional identities and espoused practices, then it meets the criteria of research that is relatable and credible.
5.10 Summary

In summary, educational research is not neutral, being underpinned by ontological and epistemological positioning. As such, my research was value laden. I was instrumental in choosing what I studied and how I intended to study it. I have made my positionality explicit in this regard. This chapter has explicated the methodological decisions made during this project and my positioning within a social constructivist and interactionist epistemology. It was for this reason that I deliberately used the first person throughout this chapter, as arguably, the notion of an ‘objective’ account written in the third person is an attempt to create the idea of research as a linear and unimpeachable process. Chapter 6 follows, where I discuss the major themes of the HIP through case description of participants as hybrid professionals.
Chapter Six

AMHP hybrid professional identities

6.0 Introduction

This chapter illuminates the case of the professional roles and identities of AMHPs as hybridised professionals, presenting case description through individual participants as embedded units within the larger case of professional identities through my conceptual framework. I argue that hybridity has three components in the HIP, though I consider these separately here; they could constitute in combination a perspective of AMHP roles and identities and practices. These are hybrid ‘perspectives in use’, visible in the range of perspectives AMHPs apply in their everyday working practices, to signify what AMHPs foreground dialogically from a range of different perspectives at their disposal; hybrid roles and boundary working. These concepts are presented in figures 4.6 and 4.7 of my conceptual framework to show the interrelated dimensions of hybridity.

Participants’ professional roles and identities through the dimension of ‘perspectives in use’ were all hybridised but displayed different dimensionalities and foci, described in Appendix W. The first group presented enacted dominant social perspectives, interwoven with legal and psychiatric perspectives. They are described as SLP hybrids. They are the cases of Annette, Kate, Elizabeth, Bernie, Tina, Matthew, Simon and William, with Annette, Bernie, Kate and Matthew presented as illustrative types of SLP hybrids. This is followed by Diana, as a case who enacted dominant psychiatric perspectives interwoven with social and legal perspectives, as a PSL hybrid. Finally, Dawn enacted dominant therapeutic perspectives interrelated with
social, legal and less prominent psychiatric perspectives as a TSL hybrid. This chapter interprets data by grouping hybrid types to answer research question two: What is a hybrid professional and in what ways is it appropriate to conceptualise AMHPs as hybrid professionals? These findings are built upon in relation to literature and presented thematically in chapter 7, with additional discussion of boundaries, collaboration and interprofessional work, hybrid roles, dialogism, ironic dialogism and dialogic identities, mapping themes across the overarching conceptual framework in figure 4.6. The narratives that follow have been extracted from fieldwork interviews with my participants. They offer my interpretation of the selected participants’ espoused professional roles and identities.

6.1 Social, legal, psychiatric hybrids (SLP hybrid)

Annette

Background

Annette was a 48-year-old female who qualified as a social worker in 2003, then an ASW in 2006, converting to AMHP in 2007. She worked in mental health services as a mental health social worker, a deputy manager, and latterly as a local authority commissioner. Her identity as a social worker was an exercise in moral values, where she stressed the importance of enacting person-centred values through her comment that ‘we are paid to make it matter’. In saying ‘we’, she is referring to social workers as a group and what is required of social workers; i.e. that social workers should ‘[be] bringing about change and do the difficult stuff’. She then discusses her feelings using the word ‘honoured’ to communicate how she perceives her social work role:
I think social workers, we are in a position, we are paid to make it matter, otherwise we should go into another job and if you can’t do that, we can’t stand up for the people making it matter and bring about change and do the difficult stuff and walk in the shit, then we should walk away because we are clearly not suited to it because we deal with some of the crappiest bits of life, because it needs to be dealt with. We should be honoured (Interview 2, 11.05.15).

Her values were connected to a moral imperative to ‘make it matter’, by stating that AMHPs ‘walk in the shit’. She highlighted the structural disadvantages that impacted on service users’ mental health problems. ‘Walking in the shit’ was both metaphorical and real for her work with individuals who self-neglected or misused drugs or alcohol. She described herself as a public servant devoted to the service of others and ‘serving many elements’, where she emphasised the boundary-crossing nature of her AMHP work that extended beyond the Code of Practice that codifies the role.

She stated that social workers saw AMHPs as embodying a different professional identity from social workers’ identity:

> I think though we are AMHPs in X we got a different identity…because the social workers talk about ‘those AMHPs’…you are seen differently to by the social workers (Interview 1, 17.11.14).

As one’s sense of self is embedded in the way a role is enacted, differences in role perception illustrated Annette’s view that her identity was different. She perceived and experienced her own professional identity in response to my question below as ‘being the voice of the people’:

> Caroline: How do you perceive your professional identity?
> Annette: I enjoy being the voice of the people who have no voice, no voice at all. I enjoy going toe to toe with people (Interview 2, 11.05.15).

This excerpt illustrated how Annette foregrounded advocating for service users through her emphasis on ‘being the voice of the people’. This was who she saw herself as being. In seeing herself is this way she was embodying into her own professional identity an aspect that represented mentally unwell service users ‘who have no voice’.
Annette’s hybrid repertoire of knowledge spanned social, legal, and psychiatric perspectives, illuminated within ‘perspectives in use’; below is an example of her social and psychiatric perspectives and how they interrelate within a hybrid repertoire of knowledge:

*I suppose I have an understanding of diagnosis... of mental illness and how that can possibly manifested in an individual...(but)...the individual for me is more important and that's putting it in a social context which is very much the heart of social work (Interview 1, 17.11.14).*

And:

... to understand what a diagnosis looks like, being able to look at a person's history, and then the presentation, to see if their symptoms are typified throughout that journey, and what that means for the service user and their family... so to understand how the symptomatology might present is very important for an AMHP in order to be able to offer alternatives, alternative structures, or even the management plan when you walk on the ward (Interview 1, 17.11.14).

Additionally, legal perspectives were foregrounded numerous times:

*From an AMHP perspective checks and balances are vital in everything that we do, making sure ...that due legal processes have been followed, that all the checks and balances have been taken into account, so in that way we are like judges, but we are making decisions for people as well, quite significant decisions based on the information we are receiving...and that’s the biggest difficulty I think when making these decision as a judge (Interview 3, 13.11.15).*

And:

*Legal knowledge I think that is my key thing, for me what the law says... when I'm on duty, when everything gets a bit all emotional, the basic tenor for me is ‘what does the law say I can do’, it doesn't matter what anyone else says I cannot do, what does the law say I can do (Interview 1, 17.11.14).*

Here Annette showed how she enacted multiple perspectives that spanned social, psychiatric and legal areas of knowledge. She stated she was ‘like a judge’, following due legal processes, and her default position was what the law stipulated should be done.
Hybrid roles

Annette compared her role to that of a judge, where she discussed the legal element of the role to other professionals and educated professionals in their legal duties:

That knowledge base is so important ...you can impart that to other professionals (Interview 3, 13.11.15).

The coercive aspects of being a law enforcer, removing people’s liberty was compared by Annette to the police officer role:

Yeah, I think those who have known an assessment before, they've had a bad experience of assessment as well, and then we think about community treatment orders and the people that engage with that and is that because all you've done is taken (the) police officer role, it’s not consensual, it's not about knowing that their mental illnesses is in such a state that they need this protective framework around them, and if that is working together the good outcomes, no it's because they going to be dragged back in, dead simple (Interview, 13.11.15).

However, the legal enforcement aspects of the role involved complex decision making:

The black-and-whiteness of the law doesn't always fit neatly within what we do, I'd say what we kind of deal with is a rainbow, a rainbow of difference in a rainbow of stuff, and some of it’s kind of dirty and some of it the nice bits but it's so varied and the law is honesty, very clean in as much as it's black and white obviously, case law colours that. But the law is the law and we will obey, and that's just the way it is (Interview 3, 13.11.15).

Her view of the law, above, indicated how hybrid roles were interrelated with boundary working where Annette navigates the complexities of AMHP practice, perceiving the work as complex, signified by her comment about the ‘nice bits’. The ‘dirty work’ comment signified the messiness and variability of working in complex practice situations. Occupying a role as a legal enforcer afforded her stability in her professional functions.

Boundary spanning

Working with myriad organisations and different professionals was a key element of
Annette’s AMHP role. She discussed this in interrelated ways. She emphasised she acted as a ‘mediator’ with other professionals involved in Mental Health Act assessments:

\[
\text{I think the role for me is one of mediator...I think across the different organisations...sometimes you soften the responses between organisations to make those bridges work better...and mediate a little bit, gets a better outcome for the service user...and to facilitate that...make sure it’s all legal and above board (Interview 3, 13.11.15).}
\]

She discussed a particularly controversial practice issue involving working with several different professionals, i.e. GPs, social workers, housing officers, etc., emphasising the skill of mediation, how this ‘makes the wheels turn...if we don’t make the wheels turn, ultimately the service user gets a bum deal’ (Interview 1, 17.11.14). This was a complex exercise of navigating differences in professional responsibilities:

\[
\text{I think (working) on the boundaries, what’s difficult is when you have good working relationships with some and they expect you to do it [Mental Health Act assessments]...that you will do a ‘favour’ by shoving her in hospital. That can be difficult to manage and my default place for everything, everything is ‘what does the law say?’...sometimes you’ve got to do that because boundaries have slipped, you’ve got to reinforce those doors, almost to protect the service user and protect your role, protect yourself as an AMHP (Interview 3, 13.11.15). Annette was acutely aware of her professional boundaries and ensured these were protected; she was legally accountable to the service user, emphasising the legal aspects of her role enacted through dialogue, seen here in her emphasis on good working relationships and navigating expectations by psychiatrists. The legal aspect therefore offered protection when boundaries become potentially porous, protecting the service user but also her role and professional identity ‘as an AMHP’:

\text{I think my job is about navigating some of those pathways to make it a little bit more just, to balance those roads a bit more because of being fair and that's what I see my job as being (Interview 1, 17.11.14).}
\]

Navigating boundaries was a significant part of the role, connected to her values of acting fairly and justly. Working across organisational and professional boundaries was intimate and emotional work that Annette was invested in. She cared about service users’ needs and placed their needs at the centre of her AMHP practice. This was what drove her desire to work with professionals and organisations with different jurisdictions:

\[
\text{I think the role from me is one of mediator, very much so and I think across the different organisations because sometimes you mediate professional responses. Sometimes you soften the responses between organisations to make those bridges}
\]
work better. Because you know you can get that kind of Mexican standoff almost, can't you between some organisations...mediate a little bit, gets a better outcome for the service user and for the whole system really that we're all trying to desperately work (Interview 3, 13.11.15).

Organisational work was fraught with tensions and ambiguities, seen here in her comment about the ‘Mexican standoff’; if she refused to engage in dialogue on the borders of organisational boundaries or professional practices, service users would not receive the best outcomes. In mediating between professionals and organisations, she highlighted how she navigated boundaries to benefit service users’ needs.

**Summary**

Hybridity was nested within Annette’s dialogue and was selectively drawn upon in various contexts at various times. By entering into a dialogue Annette became an active agent in a broader field of social workplace interactions. Annette’s professional perspectives cross-cut the social, psychiatric and legal mandates of the AMHP role. This was connected to her moral values and political focus on social justice, on being able ‘to make the wheels turn’ so the service user does not get a ‘bum deal’, navigating pathways to make them more just and least damaging for service users. Her stories of AMHP practice contained forms of knowing and belonging that were hybridised, spanning a variety of different perspectives and cross-cutting professional and organisational boundaries of practice.
**Bernie**

**Background**

Bernie was a thirty-nine-year-old female. She was a social worker and best interest assessor, and unlike other participants, she worked as a full time AMHP. This gave her unique insights into the role of the AMHP. She often worked with the same professionals on a weekly basis and, understandably, positive professional relationships emerged from the frequency of her work encounters:

*Caroline: So, what’s your relationship like with them (doctors)?*  
*Bernie: I think there’s a bit of your own personality, their own personality but generally, I feel like I get on alright with them, and we are there with different hats, different roles (Interview 1, 10.11.14).*

And:

*I think once you’re there face to face, I think it’s easier, to be nice to each other (Interview 1 10.11.14).*

I asked Bernie about her professional identity below and was surprised by her response:

*Caroline: In terms of your professional identity what would you say are the main aspects of your professional identity as an AMHP?*  
*Bernie: Crumbs!! I mean I don’t know...sometimes when you’re feeling powerless as an AMHP you feel like somebody’s bitch (laughs) because you think well I’m every body’s bitch...at one end I’m kinda powerless because of all this sort of other stuff and that’s not a nice feeling which is a bit of a contradiction to say, well everyone’s equal and then the other end of that you’re somebody in control and making a situation that has to happen, and is going to happen; happen, as good as it can, you know the best way of doing that.*

Bernie’s self-perception of feeling ‘like somebody’s bitch’ was associated by her with ‘feeling powerless’ in the AMHP role. She implies that although she had the legal power as the applicant to warrant detention under the MHA, she was hindered and constrained by other professionals. The caring aspect of her identity was important to her sense of self and was illustrated through her metaphor of feeling like ‘Miss World’. She continued the metaphor
within her discussion stating in interview 2 that an important aspect of her professional identity was ‘wanting to help others’, articulating that ‘I feel like a Miss World contest sometimes! I want to help people.’

**Perspectives in use**

Social perspectives were routinely enacted by Bernie, alongside a legal perspective. She did not discuss a therapeutic perspective and the medical perspective was always related back to the social context, foregrounding the prominence she placed upon it:

*I think in a way you do learn a lot about medical model and how it’s viewed and maybe earlier on. I wouldn’t say I don’t respect diagnosis but I see now that people don’t fit into neat boxes of schizophrenia, depression, whatever, and how many times have you met someone with a label or without one of a diagnosis who’s had shit happen to them. You kind of think in some ways it doesn’t matter what the diagnosis is, it’s how it’s affecting someone* (Interview 1, 10.11.14).

In saying, ‘*I wouldn’t say I don’t respect it*’, she was showing her critical approach to a perspective that was dominant within society and the medical field. She was dismissive of it in stating, ‘*people don’t fit in to neat boxes*’, and emphasised instead that it was the social determinants of a person’s life, the ‘*shit that happens*’, that was more important to her perspective as an AMHP, although she highlighted as an AMHP she had learnt ‘*a lot about the medical model*’. Her critical approach to medical models was drawn from her more prominent social perspectives framework and experiential knowledge.

**Hybrid roles**

Bernie occupied several hybrid roles. In two of the interviews she gave an example of the role of quasi-judge. This was imparted to her by a psychiatrist who explained how he saw the AMHP role:
He sees the AMHP as being the judge and that the two doctors have got to persuade the AMHP to sort of settle on their side of the fence if you will. And I thought that’s quite useful that, because whether you’re a doctor, the person’s care coordinator or the AMHP, there’s a lot of persuading that has got to be done and whoever, does the best persuading it’s about what the outcome is... The persuading thing, if they’ve made a good enough argument you’re doing an application feeling like you should do. You’re making it for the right reasons. And the person being assessed has an opportunity to convince me not to do it. If they can’t then I have erred on the side of caution (Interview 1, 10.11.14).

Bernie thought this role was ‘quite useful’ and she could relate to it. She saw the benefit of conceptualising her role in this way, of being persuaded by doctors and the person being assessed, balancing what was fair and proportionate in deciding to make an application or not under the Act. In describing the psychiatrist’s view of her role as a judge she was scripting a role as a quasi-judge, accepting it, seeing its value and relating to it as significant.

**Boundary spanning**

Interestingly, as previously discussed Bernie described her professional identity as being ‘somebody’s bitch,’ using this derogatory term to illustrate her frustrations. However, she also laughed to show that she was being ironic in the extract below. This insight into Bernie’s perception of her identity as ‘somebody’s bitch’ illuminated how she was constrained in her boundary working as a hybrid professional with other professional roles, priorities and systems that she navigated during a MHAA:

> Well I’m everybody’s bitch (laughs), because bed managers are giving me grief and stopping me from doing everything I need to, the doctor has said this or that, the police won’t turn up, there isn’t a bed, and you just think I’m jumping through all these other people’s hoops and I’m supposed to be in control, and I’m supposed to be kinda..., not running this show and setting this up and doing that and I’m being hindered by these other things (Interview 1, 10.11.14).

There were experienced frustrations, tensions and conflicts involved in working across professional and organisational boundaries. The independence of the role as the key coordinator was constrained by other organisational priorities, leaving Bernie feeling
powerless. However, boundary working was an integral aspect of her daily work; she described this as something that came easily to her as she was experienced in this aspect of enacting her role as an AMHP, and in understanding other roles within the MHAA process:

_"I think the longer you do it, (it) gets easier to work across the boundaries. You know a bit more about what training other professionals of groups of workers have, what they know about. I used to assume that mental health nurses knew a lot about mental health law but they get very little training, as do the police, I kind of assumed that paramedics would know about the law, they'd know how to restrain people if needed and apparently, they don’t. So, I guess it's helpful because you're thinking about if we are in the situation where such a thing is going to need to happen there’s ... no point asking the ambulance crew to do it, so I think it's helpful to know what other professionals, where they're coming from (Interview 3, 30.11.15)."

Bernie navigated and took control of the work that was required during MHAA, working between organisational systems enacting different professionals’ knowledge areas. She discussed an example of going to the magistrate’s court to obtain a warrant to legally enter a service user’s property to examine the person, and potentially remove that person to a place of safety for assessment. Although professionals’ goals to care for mentally unwell individuals may be superficially complementary, boundary spanning across the various organisational responsibilities carried inherent conflicts that she negotiated and mediated dialogically:

_"I once went to get a warrant and there were three people on the panel and they said 'no' to me, and I don’t like to be said no to, (laughs). But I was like; ‘I don't understand, can I just ask you why?’ And basically, one of them on the panel said; ‘you're very lucky there were two people on this panel today (I think they were all magistrates) that have a background in mental health’, and I thought okay, ‘explain to me why you said no?’ And they said; ‘This man that you're talking about is clearly a schizophrenic’, and it was a man who had never been in hospital and he was not known to services so he hadn't got a diagnosis, and they were saying basically the criteria of section 3 is that they must be a risk to themselves or others, and I said I'm not here to satisfy the criteria for section 3. I'm here to satisfy the criteria of the section 135 which I read to them and then they didn't know what to say...but had to tell them what the rules were which I find is quite often what an AMHP does (Interview 3, 30.11.15)."

Bernie advised magistrates on Mental Health Act responsibilities and duties, correcting their misunderstanding. By demonstrating how she attended to the magistrates’ lack of knowledge,
she had crossed into their professional legal jurisdiction to advise them of the legal duties of
the MHA, in spaces and places that sat outside her own organisation.

In relation to the magistrates, she conveyed how she communicated the rules around the
legalities of obtaining a section 135 warrant to enter a property and assess an unwell person.
The magistrates should know the rules and should advise the AMHP that they are satisfied by
the application, yet, ironically, it was Bernie who advised them:

> These are the rules and I know what are the rules, I have to tell you what they are
> because you don't know your bit of these rules (Interview 3, 30.11.15).

> ...And they were like, ‘what evidence have you got that there is mental disorder?’ and
> I say the three paragraphs in my report and say them to you again, I really had to
> spell everything out (Interview 3, 30.11.15).

These excerpts illustrate how Bernie had taken control of the magistrates’ work. The
magistrates do not know the rules, yet ironically, they are the legal enforcers of the rules.
Bernie used her evidence in her report to advise on the correct legal process, navigating
professional and organisational boundaries, accepted by both her and the magistrates. The
constraints within the system were a source of frustration:

> ...in the role of the AMHP you don't feel very powerful when you been working 12
> hours and frustrated by everybody else’s boundaries, and you just can't get anything
done (Interview 3, 30.11.15).

Additionally, Bernie felt invisible. This was particularly curious as AMHPs cross-cut so
many boundaries, which in theory would make the role more visible. So what was at play in
terms of Bernie’s role was interesting:

> It’s like dirty work, we’re not in EastEnders, AMHPs or on Corrie, they have doctors
> and nurses on soaps, but they don't really have AMHPs in anything, and it's like no
> one talks about it and people don't really know. Doctors section people according to
> the media and the world and people on the street, and nobody really knows what the
> nuts and bolts of it is and the nuts and bolts of it is us. No one can go to somebody's
> house without an AMHP, and yet legally they can't do it without the AMHP, but they
> would be really waiting to do the conveying, do all that jazz, it’s not what happens is
> it. And it's dirty work in the sense that people don't know about and they'd rather not
> know about it (Interview 2, 06.05.15).
This was connected to what was not seen in the private domain of the person’s home and was connected to stigma. It was dirty work and was internalised. It remained hidden in the private domain of someone’s living room. It was too ‘dirty’ to view, and in this way the boundary working that took place in private homes felt invisible to Bernie.

Summary

Bernie perceived her professional identity to consist of being a caring professional, however this caring aspect was compromised at times by ‘feeling like somebody’s bitch’. Bernie described AMHP work as ‘dirty work’ highlighting that although she was adept at crossing them, boundaries were fraught with ironies. She enacted a strong social perspective, which she related in being an honest professional and legal perspectives that were features of crossing boundaries with magistrates. Psychiatric perspectives were enacted critically and relationally.

Kate

Background

Kate was a 42-year-old female who qualified as an AMHP in 2007. She was a senior social worker and BIA in an older people’s mental health team. Kate saw her professional identity in terms of values, functions, roles and professional distinctiveness:

Caroline: And finally, how do you see your own professional identity?
Kate: I think a professional identity is being clear about what it is that you stand for and what it is that you do and being able to articulate that. So, it's about what your set of values is, what your functions are and what your role is. It's being clear about what makes you different from others, from other professional groups. What is it that sets us apart from other groups, from CPNs, OTs (Interview 1, 24.11.14).
And:

Caroline: Do you think you have a clear professional identity as AMHP?
Kate: - Yes, I think so, I think it's very clear (but) it is difficult to talk about and not go into the role. In terms of identity it’s about being very independent I think the independence comes through as being someone who is independent from the doctors, the care coordinators…you’re there to make an independent judgement and assessment and you’re taking with you your knowledge and your skills and your kind of bringing that to bear on the assessment. You're looking at the assessment from a social perspective as well. Weighing up everything else, and you’re coming to an independent decision and knowing that you can disagree with doctors, knowing within your role that the power’s there to be assertive. You know the alternatives to admission, you know the role, you know that the role is there to coordinate the assessment; you know what your responsibilities are legally. But I think it’s independence and knowing what your role is in that situation and how to operate it really. I think it is about independence and using the power of this in your role to advocate the best outcomes that you can get the service users even if the outcome is detention because that's what's right in those circumstances. You know bring in all your knowledge around least restrictive, human rights, all those of the knowledge bases and bringing it to bear on the situation in applying that the situation (Interview 2, 1.7.15).

Kate acknowledged that was difficult to talk about her professional identity without talking about her professional roles. She saw part of her professional identity as related to the independence of the AMHP role and how she operated within it, and how the AMHP role was distinctive from other mental health roles.

**Perspectives in use**

Kate had a strong social perspective ingrained with legal and psychiatric perspectives; this enabled her to make diverse human experiences visible. The art of this thinking was to demonstrate her broad repertoire of perspectives contextually enacted to meet diverse individual needs, enabling her to see how the connections between her professional actions with others had the potential to stimulate transformation and positive change:

*I think it's being aware of all the social factors that impinge upon somebody’s mental health and that can lead to or contribute to mental health problems, so anything from kind of issues about adversity and poverty and abuse, going up to people being socially isolated, to people being in poor accommodation, people having a lack of*
social support, people being discriminated against, gender issues, you know all those issues that impact upon those (Interview 1, 24.11.14).

And:

[The] medical model will tell you that you've got a dopamine imbalance etc. you've got schizophrenia and this is a family history, but obviously, that's not the whole picture. It’s about looking at somebody's place in society, the factors that are impacting upon them day-to-day might have shaped the development of their illness you know you might have genes, but you've also got the vulnerabilities there, so the stress vulnerability model (Interview 1, 24.11.14).

Here Kate showed a good understanding of the medical model, but her dominant perspective was the social perspective, a jurisdictional claim of the AMHP role:

Caroline: So, what is the social perspective?
Kate: Being aware of all the social factors that impinge upon somebody’s mental health that can lead to …mental health problems…adversity, poverty and abuse…. being socially isolated…poor accommodation…lack of social support, people being discriminated against (Interview 3, 19.11.15).

She emphasised the value she placed on social perspectives, and how this perspective influenced her own professional identity and underpinned her AMHP role:

I think the social model of mental health does have an influence on your professional identity and that’s with you all the time and underpins what you do (Interview 2, 1.7.15).

Interrelated with this was a concession that although psychiatrists understood social issues, emphasis was placed on AMHPs to be aware of non-medical ways of understanding mental distress, e.g. the impact of relationship issues and the effects of negative life events, such as poverty and discrimination, so although a psychiatrist:

Will reel off a number of symptoms during the interview, we are able to counter that, (we) need to have a good awareness of the various types of mental disorder and the common signs and symptoms…it’s illuminating those other factors…I think that’s quite key (Interview 3, 19.11.15).

Kate saw her role as a counter-balance to the medical role of psychiatrists. AMHPs needed psychiatric knowledge; this was only needed in so far as it enabled Kate to understand other probable factors that have produced an acute presentation of mental illness. So, although Kate was not knowledgeable in the way psychiatrists were, she had good levels of psychiatric
knowledge, e.g. of a person’s psychiatric diagnosis, therefore her knowledge crossed into psychiatrists’ professional jurisdiction.

Kate talked about her professional knowledge, skills and values in several interrelated ways. Of note was how she emphasised the importance of AMHPs’ legal knowledge, and how she understood and implemented the legal frameworks of the Mental Health Act (1983, 2007), the Mental Capacity Act (2005), and the related codes of practice which all professionals must abide by in their work as AMHPs. She emphasised her legal knowledge of children’s legislation, where she had a duty to safeguard or accommodate vulnerable children and her application of the Human Rights Act (1998); especially when consulting with nearest relatives and in complying with Articles 5 and 8 of the Human Rights Act (1998) (the right to family life and the right to privacy). She argued that AMHPs manage complex decisions daily, where legal issues go to court, unlike lawyers who ‘only tell us when we get it wrong!’ The legal framework was therefore enacted in professional practice.

**Hybrid roles**

Emphasis was placed on knowledgeable and skilled decision making undertaken routinely by AMHPs, when Kate suggested the AMHP role was akin to a court judge:

*(The) AMHP role is about making judgements, ‘mini judgements’ until the final judgement on whether or not to detain...I think judging is a massive part of what we do really (Interview 3, 19.11.15).*

Kate promoted the legal aspect of the AMHP role, particularly by expressing the word ‘massive’ to emphasise the importance she placed upon making legal judgements. The legal aspect of the AMHP role involved cutting across judges’ jurisdiction:

*When interpreting the judgements and get put into practice the judgements that the judges are making they then affect our practice. They make the judgements and we*
have to incorporate them into our practice really. I think judging is a massive part of what we do really (Interview 3, 19.11.15).

By highlighting how she retained her jurisdictional field of practice, Kate demonstrated how the AMHP role had the hallmark of professionalism and how this affords her a specialism that gave her professional identity a high status, shown by her examples of exercising leadership. In discussing similarity and difference with other professionals Kate illustrated her professional in-group membership and professional distinctiveness.

**Boundary spanning**

Various types of professional control were indicated during MHA assessments, providing a means of connection and transition across the boundaries of other professionals’ jurisdictions, e.g. managing Mental Health Act assessment and mediating professionals’ responses to it:

> Respond(ing) to unexpected issues that crop up, you know sometimes things don’t go according to plan, so I think you need to be quite flexible in dealing with situations and kind of managing other people’s response to it as well. I think about those assessments where you’ve got half the neighbours out on the streets and somebody’s shouting out of the window...so .... trying to take the lead, be a bit of a role model really to other professionals (Interview 1, 24.11.14).

Professional identities were interactive and fluid, viewed by Kate as both knowledge of the role, but significantly how this interrelated with the roles of other professionals. Working with other professionals involved constant defining and confirmation of her identity position, enacted when she faced challenge from other professionals about how to act and what decision to make:

> Obviously retaining the independence (of the role) in the face of quite dominant views that are contrary from the doctors or care coordinators (Interview 3, 19.11.15).
Leadership and skills in persuading and directing other professionals were discussed frequently, involving Kate working across professional boundaries of mental health practice, particularly when that practice jurisdiction was subject to threat from other professionals:

*I think obviously, a psychiatrist is there to diagnose, to identify signs and symptoms of mental disorder and to kind of look at whether that's the nature or degree to warrant admission, and clearly, they're doing a medical assessment. We quickly need to have an awareness or good knowledge of the various types of mental disorder that people present with, and what are the common signs and symptoms of that. And I think that's where the overlap comes in, they have a very high level of medical knowledge but we need to have a good working understanding of mental disorder and signs and symptoms as well, so I think there's an overlap in that sense. We have a good understanding of the other non-medical models of understanding mental illness as well, the biopsychosocial social models, I mean obviously, the social psychiatrists do look wider than they used to but still the emphasis is upon us to be aware of all the non-medical models (Interview 3, 19.11.15).*

Hence, Kate describes psychiatrists as only wanting to deal with psychiatric problems, whilst she wants to deal with the social issues presented by service users. In this way, psychiatric knowledge was ‘pure’ whilst AMHP knowledge was multi-dimensional, spanning the knowledge bases of law, psychiatry and its own jurisdictional claim of social perspectives.

**Summary**

Kate’s professional identity appeared to be underpinned by the social, psychiatric and medical mandates of the AMHP role. However, more emphasis was attached to social perspectives. This perspective seemed to be connected to both her social work and AMHP role, with both roles being congruent with seeing a ‘fuller picture’ to alleviate the detrimental impact of mental illness, by navigating processes, professional structures and professional roles.
**Matthew**

**Background**

Matthew qualified as a nurse in 2004. He became interested in the AMHP role whilst working on an assertive outreach team, qualifying as an AMHP in 2010. His primary interest was in mental health rather than nursing, and this attracted to him to a post in a multidisciplinary assertive outreach team, working with ASWs/AMHPs. He believed his nursing identity contained several commonalities with the AMHP role, such as a compassionate caring valuing base, so he decided he wanted to train as an AMHP ‘because it was my service users going in, I wanted to be in that supportive role’ (Interview 1, 13.01.15).

**Perspectives in use**

A multitude of perspectives were discussed in knowledgeable ways by Matthew. These included the medial perspective, where he believed the AMHP role controversially needed ‘that knowledge of nursing’ and ‘that social function, it brings everything into it’ (Interview 1, 13.01.15). The legal elements of the role were seen by him as providing an underpinning framework for practice, including knowledge of human rights legislation:

*You know you've got your Mental Health Act stuff, you've got the law that runs alongside that supporting it, you've got human rights, elements of that, you've got MCA, so you've got a lot of different legislations that is used to pull in, but you've got to know alongside your experience when you're using it. There are things you have to look at and adhere to and to follow, but it's how you follow that alongside your practice to get to the point you want to get to...when you're looking at legal aspects of stuff, to focus differently and not become over involved with the legal side of things or the MCA side or whatever other legislation might be, there's a knowledge there but not to kind of have that as a driver (Interview 1, 13.01.15).*

The social perspective was interrelated with knowledge of the impact of inequalities:
Cheap housing, drugs issues, cultures of change within that, round here you are large Asian population kind of Pakistani Bangladeshi background. So, it's an unusual place in you've got quite severe at times urban deprivation but within 15 minutes you can be out into million pound houses, the area is quite complex, there's massive inequalities within a small area. So, for me, you've got to have that knowledge and it helps for me working in a similar area to where I grew up, having that awareness of people and what life limitations and difficulties they face (Interview 1, 13.01.15).

Hybridisation of perspectives was a strong element in Matthew’s espoused professional role, as he stated:

*I’ll be honest with you, (I) see the role as quite generic, it really is... I just think they should be more focus on the psychosocial aspects of care rather than it being medical stuff... You still got your identity but, you need that crossover* (Interview 1, 13.01.15).

The value placed on social perspectives was attenuated as a part of his hybridised repertoire of knowledge:

*But, obviously within that, but I'd be coming as a nurse, but especially with working assertive outreach, more socially focused with how it works* (Interview 1, 13.01.15).

The medical knowledge gained from his nurse role, was applied to social settings and social perspectives in the AMHP role, where Matthew selectively drew on a myriad of perspectives, that demonstrated a pluralistic approach to mental health practice, defying the traditional boundaries of traditionally fixed professions and professional roles:

*I bring that medical knowledge into that social setting, so I think eventually people started to learn about me as well in a way* (Interview 1, 13.01.15).

Here he was interrelating medical, social and legal aspects of his AMHP role, demonstrating strong salience with a hybridised professional identity. His psychiatric knowledge unsurprisingly was an area of expertise that he routinely drew upon, although:

*I don't think you need the ins and outs of how that functions within the brain itself, and certainly from the disorders, from depression through to paranoid schizophrenia - how that impacts and how that functions and how it is eroded in people, but it's keeping an open mind because what one psychiatrist thinks may well be schizophrenia and other may well think not. But it's not for me, it's beyond me to be arguing what is a mental disorder, it’s the psychiatrist; doctors are making their informed decision – ‘that there is a disorder’ that is fine* (Interview 1, 13.01.15).

Rather, he addressed the function and impact of ‘disorder’, the risks and what care and
treatment plan was required to keep the person safe. Although he tried to ‘leave my
‘nursery’ head to one side, it does help obviously when psychiatrists are talking about
things that I have in common with them’ (Interview 3, 03.11.15).

(I’ve) got family here going to be supportive and he’s willing to give it a go...So
going to exercise the 14 days and come back, then it’s quite empowering in some
sense, but justified rather than just carting people in... But from the therapy point
you can go where you can try and educate people and give people the options and
explain what it means in terms of recovery, so if you respond this way this will
allow you to actively engage better and stay out of hospital, so it’s therapy but
broad (Interview 3, 03.11.15).

Therapeutic enactment of the role was shown through work with service users, carers and
families when he used fourteen days to consider a home-based care and treatment plan,
knowing he could still make a valid application for detention within this time if the situation
deteriorated. He indicated his role had a therapeutic element by stating ‘it’s therapy but
broad’, but he did not perceive himself to be a therapist.

**Hybrid roles**

Matthew was attracted to the legal elements of the AMHP role:

*The role though it brings everything, it tends to be legal issues of role and not nurses’
role. So, at that time tentatively I was kind of interested in it* (Interview 1, 13.01.15).

Recognising that although he was not a lawyer, it was a knowledge area that he wished to
develop, using ironic banter to state that this was not his primary concern in the AMHP role:

*I have my own view (on) that. I think some AMHPs would love to be a lawyer or a
judge* (Interview 3, 03.11.15).

Ironic banter was used by Matthew as a way of stating the multidimensional nature of the
role, ‘you’re judge jury and executioner, because you’re the one who’s signed the application,
the medics aren’t and keep that in your head is healthy (Interview 3, 03.11.15).

The judge’s role had strong parallels to the AMHP role, particularly weighing evidence
and judging of a range of contradictory views. However, it substantially differed in the sense that AMHPs were dealing with live situations of great complexity and risk in an uncontrolled dynamic environment:

*Similar in the sense that someone is disordered, but circumstances are different, different people, so different. But with the evidence judges are provided with that third-party, we've got our own ability to get it right from the mouth, you can build up in that environment there and then in that setting and pull on the information that you had before. Judges respectfully are in a controlled environment, we are looking out, they're sitting still and listening. So, we've got a bit better ability to influence, make decisions more around informed decision-making. We've got a live situation, and we've got a better picture (Interview 3, 03.11.15).*

Matthew encountered significant derision in his AMHP training and during the early years of his AMHP role. For example:

> ‘Oh, he's the token nurse kind of thing’, but as times gone on and relationships have kind of evolved, people change don't they, when they can actually understand that I can actually do the role. You know I'm not just sticking everybody in because the doctor says so! You know the role itself that was there for just social workers, I think the training is different you know, we do come from different types of polls if you like, but we are integrated, we do crossover (Interview 1, 13.01.15).

Here he illustrated allegiance to role, although he acknowledges that social workers and nurses come from ‘*different poles*’, emphasising the contested medical social binary. He narrated how he was not swayed by a hierarchal health system of the doctor knowing what was best for service users. However, it was necessary that he stated this to demonstrate that he was a fully-fledged AMHP, an authentic member of the in-group. As a nurse AMHP his AMHP role was scrutinised by practising social work AMHPs. He viewed his practice as an AMHP to be related to a district role rather than as an embodiment of his professional identity, stating that ‘*once in my role I identify myself as an Approved Mental Health Professional*’ (Interview 1, 13.01.15).

However, he later stated:

> *I don't just identify myself as just an AMHP or a nurse, it's kind of whatever situation I'm in or asked to be in, and it's part of my role* (Interview 1, 13.01.15).
Interestingly, he locates how he introduces himself to service users as both an AMHP and a nurse:

Matthew: I don't know, ... dislike... it seems to give you the fountain of all knowledge probably, you're the one that knows, and if it's when you're discussing it with service users. 'I'm Approved Mental Health Professional’, then to me feels arsey, as it seems to me from the outset to give that aura of power. I don't like it. Now I know I need to use it because that's the role I'm taking. But I don't feel comfortable. So, I tend to at times (to) say, 'That's my role but I'm also a nurse. But I'm here to listen to you and to understand what it is, so let’s take that out of it’. It's a legal bit... So, I tried to get that out of the way quickly really (Interview 1, 13.01.15).

The power of the role, as legal enforcer who removes a person’s liberty, was straddled with the perceived role of the nurse as a caring professional. Here the role was separated out, so Matthew was more than a professional who from a position of power detained a person; he also had other dimensions to his role that he made visible for service users. In his enactment of the role with other professionals, however, the status and power differentials that he sought to reduce with service users were viewed by him as a desirable element of the role:

Caroline: What's unique about the role?
Matthew: I think what is unique is how you’re received, that you tend to get a different reception, in respect of how you’re listened to, you certainly get that from doctors; and stuff...You tend to get people coming to you more often for that knowledge rather than I think necessarily if it was just me being in a CPN (Community Psychiatric Nurse) role (Interview 1, 13.01.15).

The knowledge he had gained in the AMHP role was enhancing, particularly as ‘doctors listen’ to the AMHP and other ‘people come to you for your expertise’. Matthew viewed these aspects of holding expert knowledge in his AMHP practice as status enhancing. He believed his AMHP ‘expertise’ had given him a higher status with psychiatrists, above his previous status as a nurse.
Boundary spanning

Matthew worked with a wide array of different professionals in an expansive professional interconnected network of activity that occurred during Mental Health Act work:

Caroline: So, is there anybody else that you would be working with is an AMHP?
Matthew: Well you've got everybody and anybody haven't you, safeguarding, you could be working with child social services, you could be working with third party providers, counselling service, IAPT [psychology]- I don't think there's any end to it really, you work with whoever is involved; carers, family friends, friends of friends. Got that liaison role as well- at courts, 135, you've got to do the liaison with the courts with the clerk initially to set that all up, magistrates, magistrates articulating the need for them to give you the authority, to smash the door in, it's hard to articulate that (Interview 3, 03.11.15).

And:

Caroline: So, is that extended professional networks?
Matthew: I'd say so yes, is seeking work, what services are out there, and I think you do learn as an AMHP as well because you come across things that are available that I'd never heard of before! So, it's keeping that in, keeping that in mind. I think that again, some of it should be knowledge of alternatives. But I think it's about yourself as an individual, your own interpersonal skills, your ability to adapt and change to settings that you may find yourself in. I mean you're entering people’s homes ordinarily, which are private, you know you're very intrusive on their life, you've to kind of be able to understand that before you get in there, do you know what I mean? (Interview 1, 13.01.2015).

However, there were barriers with cross-cutting professional boundaries, as it could be isolating, frustrating and pressurised:

...it’s still for me that feeling that you're kind of out there on your own, when you're dealing with that situation. You're the one that is meant to coordinate everything, control the situation, link in with everyone, liaise with everyone, but despite that you still find yourself up against barriers with everybody (Interview 3, 03.11.15).

In the above excerpt, barriers to boundary working were highlighted by Matthew as problematic and frustrating, particularly because the ultimate responsibility for admitting individuals to hospital was an AMHP duty under the MHA (1983, 2007).
Summary

Matthew’s espoused professional roles and identities were visible in stories of AMHP practice, demonstrating how professional roles were enmeshed and identities dialogically enacted in whatever needed to be ‘draw(n) upon that day’:

*I don’t try to say I’m here as an AMHP, I’m here as Matthew, that's me, to fulfil this knowledge from me... No just tend to go as me, and any knowledge that is there, (I) use in any way I can do. And don't know if that's me as a nurse coming from that background or is it me as an individual (Interview 1, 13.01.15).*

He occupied multiple positions and negotiated across boundaries of professional practice in complex ways. Indeed, his professional identity could be viewed as one of a ‘portfolio of identities’; his expressed identities were particularly pluralist. His multiple roles gave him kudos that he highly valued:

*Ultimately, so it’s about developing me and developing my person and some of that was conscious but some of that was happening in an unconscious way, what I mean by that is, you do change, your attitudes and values change in your outlook changes and I think that's a good thing (Interview 3, 03.11.15).*

Matthew’s identities were transitional and fluid, showing a deep connection to past experiences, connected back to his intimate present day concerns and values. The identity positions that Matthew narrated established his influence as a well-regarded professional who was ‘deserving’ of the role of AMHP.
6.2 Psychiatric, social, legal hybrid (PSL hybrid)

Diana

Background

Diana was a senior social worker who qualified as an ASW twenty three years ago. She supervised social workers from the city community mental health teams, holding a coordinating function in her organisation’s AMHP hub. This was where AMHP referrals were screened and dispatched. Diana undertook a psychiatric social work qualification and worked from her early twenties in mental health settings. While studying for A’ Levels she volunteered at an asylum (as it was called then), and described an event where she managed to get a female who was non-responsive previously to engage with her, by playing a game of catch:

*Caroline: And how did it make you feel to make that difference?*

*Diana: Oh great, as in the story of getting the lady to throw the beanbag back to me that was 35 years late, I still remember skipping home that day. And I thought ‘gosh you can go to work and feel like that’ that's great, I’ll have some of that (Interview 1, 12.11.14).*

Making a valued difference was a component of her professional identity, and she linked this aspect to her overall identity as a person and as a professional as follows:

*So, it was seeing how mental illness affects different people...seeing what people can do to make a difference and that it's not hopeless and worthless you can do something, you can't cure people, you can't give them the world but you can make life a bit better and that's what I saw even if it's just a smile, that it was worth putting the effort in (Interview 1, 12.11.14).*
Perspectives in use

Psychiatric knowledge was highly valued by Diana. Unlike other participants, she used psychiatric language in her everyday professional talk, always referring to the person as a ‘patient’. Examples are given below:

*I'm in the living room and they're in the kitchen, and I can see them in there opening cupboards, poor client she was saying, 'What are they doing? Stop it'. They were there looking at medication, they were going upstairs, I think it was just what they do, so I asked them to stay outside please you are upsetting the patient (Interview 1, 12.11.14).*

And:

*Joint assessments with the first recommending Dr. are hardly ever happening, back in the day we had a policy where we would refuse to take referral from anybody other than the doctor who had seen the patient (Interview 1, 12.11.14).*

This illustrated her hybridisation across a psychiatric spectrum, where language signified her identity positioning linked to graduating from a psychiatric social work course, and how she was:

*...steeped in the knowledge of your chosen field and I think it is essential, you have to know signs and symptoms, you have to know what is mental disorder and what isn't, what is just personality and behaviour, you have to know the effects of medication, because sometimes they can look like a psychiatric symptom but they're not. What is a negative symptoms of schizophrenia as opposed to the sedative effects of medication, although not getting out of bed because it's negative symptom or because they're so sedated, you need to know these things. And I think more of the professions are looking at the social perspectives because I think we are to a certain extent almost generic workers now (Interview 1, 12.11.14).*

It was interesting that she commented that more members of the profession were enacting social perspectives rather than saying she looked through this lens. It was clearly not where her dominant ‘perspectives in use’ lay; rather, she was steeped in dominant psychiatric perspectives of mental health and was enthusiastic about her interest in psychiatric knowledge:
I read that about bipolar or schizophrenia or depression it was a real page turner. I absolutely loved finding out what the different treatments were (Interview 1, 12.11.14).

She reinforced the emphasis she placed on her psychiatric knowledge, believing that she had a thorough understanding of diagnosis and medication, equivalent to that of a psychiatric nurse:

You definitely need to have psychiatric knowledge. I can't, I can't imagine how you could do an assessment if you don't know one illness from another, one disorder from another if you can't talk about treatments, side-effects, because a lot of the people you assess say, 'I came off my medication because...' You know, and you need to understand that they're not lying to you, that they're telling you the truth, and I don't think that level of knowledge is any is any more than maybe a psychiatric nurse, well, certainly not in the realms of the psychiatrist. He will understand the chemistry and illness, you know the physiology of an illness, that's not the level to which we were educated (Interview 3, 6.11.15).

Legal perspectives were key within the role, where she referred to the legal books routinely consulted to clarify points of law:

(I)would be sitting there with that Jones open; looking for information, discussing the information discussing the different points of law, which is what I grew up with (Interview 1, 12.11.14).

In referring to ‘what she grew up with’, she located how she has been educated to use a legal perspective and was foregrounding this as an important area of her practice knowledge. She also illustrated her use of social perspectives; interestingly, relating this to risk issues rather than social justice issues:

And I think more of the professions are looking at the social perspectives because I think we are to a certain extent almost generic workers now, I think what makes an AMHP different is the risk that an AMHP or even social worker is prepared to work with, I think we have a far higher tolerance of risk (Interview 1, 12.11.14).

She believed she was generic worker; the only aspect that separated out her other roles from her AMHP role was the higher threshold of risk she stated AMHPs routinely work with. She believed more members of the mental health profession value social perspectives, although this was not where her dominant ‘perspectives in use’ were enacted.
Several hybrid roles are highlighted; an example of what she evidently perceives her role similarity to be to that of lawyers is below:

...we look at patients’ rights, at the beginning when we did an assessment, if we do detain somebody we’re the ones who are telling the patient what their rights are, the nearest relative what their rights are, have you got a leaflet explains it, that explains it in the language that is their mother tongue, is anybody going to help the patient get an IMHA, so in that kind of way I think we have a lot in common if we’re both looking at patient’s rights (Interview 3, 6.11.15).

But, unlike other participants, she did not fully perceive the role to be like that of a judge:

Caroline: Judges?
Diana: Similar only in upholding the law (Interview 3, 6.11.15).

Interestingly, Diana did not believe the AMHP role to be therapeutic at all:

Caroline: Do you think you use therapeutic skills during the assessment?
Diana: I think it's common sense skills to reduce risks, to reduce anxiety to get somebody to talk to you. They're not therapeutic skills at all. That's not my role and I think you're opening Pandora's box if you start on that (Interview 3, 6.11.15).

Here she counselled against acting therapeutically, describing this as ‘opening up Pandora’s box’. The process of MHAA meant that if AMHPs were to act therapeutically, they could potentially unravel individuals’ complex problems. This could lead to an increase in risk for service users and others. The AMHP role required management of the risk of harm to individuals and others. In the excerpt above, Diana was counselling against acting in a therapeutic way because she perceived this elevated such risks.

Diana used a metaphor to describe her role as a ‘big bad wolf’, highlighting the power of her role as a detainer and as a professional whom people fear, with the role feeling like ‘dirty work’:

Because what you're doing is horrendous, you're dragging somebody out of their home against their will, you're going to detain them in hospital against their will, they're going to be forced to take, you're doing the right thing you can't just be
blasé about that, you have to remember the impact that your actions are having on people. When somebody says, ‘Look I just need to go home look after my kids’, you say, ‘Sorry I can’t let you do that because actually I think you’re possibly going to harm your children’. And it's hard because at the time that it's happening you've got be firm and sometimes have almost got to be brutal and that's awful, because what you really want to do is put your arm around them and say I get this ‘I know how horrendous this is’, and you're stuck between having to do what you're doing because it is the right thing to do and yet wanting to side against yourself because you're being the big bad Wolf (my emphasis) (Interview 2, 23.04.15).

Multiple roles were illuminated, and the tensions between exercising care and control functions of the AMHP role were illustrated in her perception of feeling like the ‘big bad wolf.’ Feeling like the ‘big bad wolf’ showed internal conflicts within her role, where she was balancing professional dilemmas, and feeling stuck between these two colliding value systems, highlighting the difference between what she wanted to do, ‘put your arm around them’, as opposed to what she must do, ‘the right thing’, i.e. detention under the MHA.

**Boundary spanning**

Diana discussed the professionals that she worked with to illustrate the nature of boundary spanning across professional and organisational remits, especially in the coordination role when she detained a person under the MHA:

> Everybody's got a specific role, so, ‘backup worker can you go outside and make these particular phone calls’, then informing the police ‘okay this is where the bed is, because of risks would you be able to convey’ or ‘actually we don't feel the conveyance risks so you going to call an ambulance’, ‘who's going to lock up?’, you know it's a kind of saying and the doctors can walk away, sign the forms, 'here you are, I'm going.' So, you are the person that is left to ensure that everything else goes smoothly (Interview 1, 12.11.14).

And:

> We are liaising with the magistrates. We need to call the police and arrange for them to come out and execute the warrant even if there isn't a warrant, if we think there are risks we will ask the police to accompany us. We work with two doctors, say they need to be organised, we will liaise with housing, with locksmiths and ambulance if we need it, and then other organisations who is there involved with that person who we're assessing. So, care coordinators, I suppose some of the same organisation but a different part of it.... Then there may be other people (Interview 3, 6.11.15).
A negative aspect of boundary working was experienced when Diana faced obstacles in her ability to enact the role successfully:

*Diana:*...goes to the person who manages bed management, and if you can get hold of them, because last week we had an issue and I said, 'okay I've just had a meeting with that person, so okay go to her...' She's on holiday and the other people were all on holiday.
*Caroline:* So many obstacles?
*Diana:* All the time, all the time and then the other one is that there's only one duty SPR and one consultant (Interview 3, 6.11.15).

The obstacles experienced in both securing a bed and the doctors required to attend the MHAA were highlighted, and placed AMHPs’ jurisdictions beyond the immediate control of their own organisation’s requirements to span across other organisations’ priorities. Obstacles to the ways AMHP work was organised was a routine aspect of professional practice.

**Summary**

Diana located her hybrid professional role as that of a psychiatrically knowledgeable AMHP who foregrounded predominantly psychiatric and then legal and social perspectives. The language used was ‘borrowed’ from medicine, showing that she crossed into this territory through her ‘perspectives in use’. The hybrid roles she drew upon parallel this through perceptions of having the same knowledge as a psychiatric nurse and strong role similarity to lawyers. Negative aspects of working across organisational boundaries were salient features of her boundary working, involving navigating obstacles and trying to organise doctors’ attendance at MHAA.
6.3 Therapeutic, social, legal hybrid (TSL hybrid)

**Dawn**

*Background*

Dawn was only one of four AMHP occupational therapists (OTs) in England, which made her insights valuable for researching the AMHP role and multi-professional identities. She belonged to a trust that was the pilot site for extending the AMHP training to other professionals, and seized this opportunity when it arose. This was driven by her desire to provide holistic care and support for vulnerable individuals with mental health issues. She qualified as an OT when she was twenty-six years old and then joined a specialist community homeless team, where she has been for eleven years. She decided to train as an AMHP after being encouraged by her AMHP manager:

> ...then my manager was a social work AMHP, like I said, we got talking one day about my interests and my PDP and she said; ‘What about becoming an AMHP?’. It was really important to keep it within the team to maintain their ethos and I was the drive behind that (Interview 1, 17.11.14).

I asked Dawn if there was a change in how she perceived her professional self when she became an AMHP. She stated:

> It consolidated that I was on the right path, that my views weren't totally left-wing, that I had the same values as everybody else on that course, and it was good to know that, and it was good to know that actually, yes, I am good at my job and to feel valued by others I think is really important in maintaining your professional identity (Interview 1, 17.11.14).

As an occupational therapist and AMHP, Dawn felt she had the same values as social work AMHPs. She felt she was part of an AMHP professional group, indicated by her comment of ‘feel valued by others’. Feeling validated and ‘good at her job’ was, she said, important for maintaining her own professional identity as an AMHP.
I came back how she perceived her professional identities in interview 2:

Caroline: So, in terms of the AMHP identity do you see it as a role or do you see it has seeped into the whole of your professional identity now, in terms of everything you do?
Dawn: Absolutely is more than a role it's a way of working isn't it (Interview 2, 19.05.15).

In indicating that it was ‘more than a role, it is a way of working’, Dawn had incorporated within her work as an AMHP a narrative of her everyday working practices.

**Perspectives in use**

Being a visionary and a pioneer was a narrative threaded throughout Dawn’s self-perception of her professional identity. This was illustrated by her story of being a key influencer of team culture, where there was a social perspectives ethos:

*Then I did my expression of interest and there was three or four of us who are non-social workers, who got on the course. I think it all just happened at the right time you know the development of the whole new AMHP, new ways of working, new Cheshire West developments, fitted in well with the time. I decided to do my work and that’s why I am where I am today* (Interview 2, 19.05.15).

And through her willingness to try new things:

*So, if the role hadn’t been available to non-social workers I wouldn’t be an AMHP now. So, it’s purely on the basis that they extended the lack of AMHPs I think throughout the country that I am the only (OT) AMHP now, so being an OT and innovative and myself I like to try new things, I’m a pioneer ... You know. Why not? Why can’t OTs be AMHPs and to prove people wrong really?* (Interview 3, 17.11.14).

This was an extension of her ‘love of mental health’ wanting to ‘make the right decisions’, having an extended evidence base that was ethical on which to draw upon selectively in her work with homeless people with mental health issues. This coincided with increased perceived status in her role as an AMHP, whereas as an OT:

*You get battered as an OT you know, people just dismiss you, dismiss your work as just distracting boredom, anxiety management you know board games. You got to be able to read right and understand listen comprehend* (Interview 2, 19.05.15).
This suggested an extension of her traditional OT role into an AMHP role, promoting hybridisation in her professional perspectives:

_This drove my experiences as an OT, to venture out into different roles I think that says a lot about me in the way I view work, my knowledge and I'm very creative as an AMHP_ (Interview 2, 19.05.15).

Dawn illustrated how her knowledge areas spanned therapeutic, legal, psychiatric and social perspectives, but significantly the ways these were foregrounded was dependent on who she was in dialogue with. Knowledge was therefore selected contextually with professionals:

_So as much as we might preach our AMHP practice and the law to the psychiatrists when I'm deciding whether it's a two or three or who the nearest relative is and how I've worked that out, I would always... So, suppose we've got legal knowledge haven't we, but I wouldn't say that am an adviser or somebody to come to, because I would always say this is just me, what I think, check it out with legal_ (Interview 3, 17.11.15).

Equally, she drew on the social perspectives of mental disorder:

..._as an OT you're taught everything, it makes you quite aware, you know the social model of disability, yellow buses and the stigma it's just ingrained in you_ (Interview 1, 17.11.14).

Psychiatric knowledge was located within her practice, where she stressed the importance of understanding diagnosis. But her expertise did not extend to an understanding of medication options:

_Looking holistically obviously in terms of balancing risks, the health and safety and whether they meet the criteria for detention, because psychiatrists would have to make medical recommendations, so I'd have to make sure that I know what they're talking about really, my understanding of their health conditions. They'd probably diagnose whereas I wouldn't, so they properly work more with diagnosis and may be more focused on the type of medication that the person would be having a treatment, whereas I don't think I would have that skill to maybe say go on olanzapine rather than risperidone_ (Interview 3, 17.11.15).

As an occupational therapist and AMHP, Dawn felt she had the same values as social work AMHPs on the course. She was accepted as being part of an in-group: _‘to feel valued by others I think is important in maintaining your professional identity’_ (Interview 1, 17.11.14).
Feeling valued by social work AMHPs was an important aspect of her espoused identities. In the excerpt, she placed importance on other professional members valuing her, highlighting her need for acceptance into the AMHP role and her professional identity as an occupational therapist, not a social worker.

**Hybrid Roles**

Dawn stated that she occupied two roles simultaneously. She was not an occupational therapist AMHP; she says she was ‘an OT and an AMHP’:

> A variety of roles I've never had any tension, there's only ever one AMHP who ever introduces me as the OT AMHP, laughs... I don't introduce myself as that, I'm not, I'm an OT and AMHP (Interview 1, 17.11.14).

How others acknowledged her roles was significant, as although there was a clear separation out for her between the two professional roles, she experienced other professionals introducing her in this way, as an OT AMHP. It was significant that social work AMHPs did not introduce themselves in any other way than as an ‘AMHP’ have a need to ‘other’ health professional AMHPs. She also compared her AMHP role to a judge: ‘it's like (you're both) ...judge and jury’.

Dawn illuminated the hybrid nature of roles in mental health services:

> But I think the Mental Health Act assessment is probably similar to my role as community practitioner as a generic worker (Interview 3, 17.11.15).

As an occupational therapist, Dawn engaged me in ironic banter when I asked if the AMHP was like a therapist:

> Caroline: How about therapists? Do you think the AMHP acts in anyway as a therapist in the process?  
Dawn: Of course I am, I'm going to say that!! (laughs)  
Caroline: You would!! (laughs)  
Dawn: You find yourself, I found myself in situations where have had to stay in the house with the person I’ve detained. I need to make small talk or something, so I will use my therapeutic skills to gain more information, to see if I can in any way work on whatever their issues are, advice, signposting, in a more informal way, as much as I've signed that pink paper and stuff at the end of the day they've still got things that need resolving (Interview 3, 17.11.15).
Throughout the interviews, Dawn interchangeably used hybridised language, and perhaps she drew on this selectively in her practice, depending on context and whom she was relating to, potentially demonstrating her relational skills as a hybrid professional.

**Boundary spanning**

Cross-cutting myriad organisational jurisdictions was an area of complexity and challenge in exercising hybridity. This ranged from advising GPs, ‘I think as an AMHP we often find ourselves advising GPs’, to understanding the intricacies of how the police department works, to manage the cross-cutting nature of the role:

> So those are some of the barriers I've had to work across the police and obviously, you're negotiating and trying to compromise with them, how best can we move forward then...sometimes you can't move forward without the police, and sometimes you have to abandon assessments because you can't get them and that's not the AMHP's fault it's just a system, you've tried to get this person assessed, and then you've got to weigh on balance of risk 'am I going to go when not having a bed, to assess this guy? (Interview 3, 17.11.15).

Boundary working had enabling and constraining factors for Dawn, with compromise and negotiation being key strategies for enabling smooth assessments. However, systemic issues impacted on MHAA, resulting in assessments that were often subject false starts, delays and abandonment. These delays occurred through a lack of resources for psychiatric beds, and through ambulance and police members’ limited availability to convey the patient to hospital. Limited resources led to serious consequence for the assessed patient; for example, Dawn’s ability to use alternative care and treatment plans in the community was constrained by crisis and home treatments teams’ constrained resources.
**Summary**

Dawn’s pluralistic professional identities were demonstrated through her sophisticated ways of selecting, drawing and narrating her role hybridity. She discussed demarcation between her occupational therapist and AMHP roles, and had incorporated both roles into a ‘way of working’, illustrating the fluidity of her professional roles. It seemed that she drew on the knowledge areas of both roles in her everyday practice. It was interesting that she perceived a strong synergy between her occupational therapy values and AMHP values. Of note was the value she placed on the therapeutic aspects of the AMHP role, coupled with feeling like both judge and jury in weighing up the sometimes contradictory opinions of other professionals, before making a decision as ‘judge’. This was one aspect of her boundary working.

**6.4 Chapter summary and key outcomes**

Data illustrated various features of hybridity within and across participants through their ‘perspectives in use’, enactment of hybrid roles and boundary working. Boundary spanning was complex; it was both an enabler and constrainer within the everyday practices of participants’ professional AMHP practice. Working across the boundaries of other organisations was frustrating and subject to false starts and improvisation. Participants were constrained by other organisation remits and rules, although AMHP had legal duties that enabled them to cross into other organisational remits and priorities, such as the duty of conveyance under section 6, MHA (Department of Health, 1983) to legally require police and/or ambulance attendance. Ironically, this duty was *negotiated*, and was subject to outside organisations’ own priorities. In this way, participants relied on their ‘perspectives in use’, to show other professionals how their knowledge was drawn from several other disciplines;
namely, psychiatry, law and social work. They demonstrated how they selected knowledge contextually with different professionals to achieve the outcomes they were duty-bound to fulfil, cross-cutting into knowledge areas from different fields of professional practice. This knowledge was enabling; it was used to enable boundary working when AMHPs experienced false starts and delays.

Participants’ boundary spanning was enacted within identity positionings and repositionings, in events of MHAA, constituting realities that the professional world was informed by the experience of others (Holland et al., 1998; Hoyle and Wallace, 2005). Identities as they were enacted were dialogical at moments of expression, listening and speaking. Because the self was the nexus of activity in which it also participated, it could not be finalised. Identities were reflexive and dialogical as the views of others were necessary for ‘authoring the self.’ In their stories, participants position and were positioned by narratives of the sameness and difference (Jenkins, 2008), in the ways they narrated how they were ‘like a judge’ in one sense but different in another, e.g. in their application of the law in people’s homes, situated in dynamic and crisis ridden situations, complicated by risk. These narratives provided examples of how participants expressed the complexities of their espoused professional roles and identities.

The following chapter builds on this chapter in considering the major themes within the study, drawing on the dataset in relation to the overarching conceptual framework in Figure 4.6. In doing so, it extends scholarly understandings of hybridity and suggests that AMHPs could be conceptualised as hybrid professionals negotiating dialogical identities.
Chapter Seven

Enacting hybridity through dialogism

7.0 Introduction

This concluding chapter is structured as follows. Firstly, I discuss how hybridity is enacted through dialogism through the themes of ‘perspectives in use’, boundary spanning, hybrid roles, ‘ironies of representation’ and ‘ironies of adaptation’ (Hoyle and Wallace, 2005, 2007). Secondly, I discuss a new form of irony illuminated through my concept of ironic dialogism. Finally, I make links between hybridity and dialogism. The conceptual framework discussed in Figure 4.6 is deployed analytically.

The importance of professional identities as social and relational in nature is attenuated, with the significance of events as a means of revealing AMHP professional roles and identities illuminated. The workplace was not a static location but spanned numerous public areas and the private domain of individuals’ homes. Participants were part of networks comprising individuals, teams, services and organisations. They interfaced with users of these services and in the complex environment around them. Professional identities were not stable entities; they were an ongoing process of interpretation and customisation, shaped through events in the workplace and in personal life. Enacting identities was intimately connected with participants’ values, and was experientially located through narratives which accrued within and around identity enactment. These narratives incorporated values, skills and knowledge locations. They drew upon perspectives, selectively and contextually. These narratives are
named as ‘perspectives in use’ to stipulate the ways participants used perspectives in their
everyday work dialogically (Holquist, 2002).

Participants’ ‘perspectives in use’ were hybridised, in the sense that they drew on a repertoire
of social, legal, psychiatric and therapeutic perspectives, and the roles drawn upon in their
everyday practice were multifarious. This created flux within identities and an ‘ironic
orientation’ (Hoyle and Wallace, 2005). As participants worked in contingent circumstances,
this created ironies in their practices, that were often resolved through ‘ironies of
representation’ and ‘ironies of adaption’ (Hoyle and Wallace, 2005, 2007). Drawing upon
Hoyle and Wallace’s work (2005), an ‘ironic orientation’ recognises the contingency of
professional practice, takes a pragmatic approach to problem solving, and enacts solutions
from a broad repertoire of ‘perspectives in use’, experience and intuition, reflecting on what
has been successful or not. Extending Hoyle and Wallace’s (2005) ideas, I illustrate how
AMHPs are hybrid professionals who embody wider roles from other professions, through
their ‘perspectives in use’, hybrid roles and boundary spanning.

Participants resisted pressures placed upon them by organisational requirements, resisting the
instructions of bed managers, for example. Rather than jeopardise their position in the
organisation by openly expressing resistance, they enacted narratives that embodied their
conflicting perceptions, drawing on irony to manage the conflicts that arose. AMHP
hybridisation took place across the boundaries of organisations, and with other professionals,
involving the navigation of everyday practices. Although the role of the AMHP has been
identified as socio-legal (Quirk et al, 2001; Rapaport; 2006), participants narrated how they
must be prepared to do things outside of the boundary of their codified, regulated role. The
mechanisms for achieving the enactment of this were dialogical in nature (Holquist, 2002).
Jurisdictional disputes embodied the nature of hybridisation as participants dialogically navigated and cross-cut traditional organisational boundaries, acting with a high degree of autonomy, leadership and wisdom. When professionals succeed in negotiating and enacting change, jurisdictional boundaries are crossed. Boundary spanning was connected to their mission as caring professionals. This mission, what intimately concerns them, was enmeshed with acting humanely in inhumane circumstances, encountered during MHAA. As boundary spanners (Walter, 2003; Nissen, 2010; Oliver, 2013), AMHPs cross-cut traditional areas of professional practice. As Bourdieu proposes:

> What is at stake in the struggles of the social world is power over classificatory schemes and the systems which are the basis for the representation of groups and therefore of their mobilization and demobilization (1984, p.479).

The mobilisation and demobilisation of classificatory schemes, through ‘perspective in use’ were enacted by AMHPs contextually and situationally. Such perspectives in use in representing ‘broad knowledge areas’ (Noordegraaf, 2007) appear to represent participants’ hybrid professionalism. These related aspects have been found in my study and are discussed in detail throughout this chapter.

### 7.1 Hybrid perspectives in use

Mental distress is a profoundly complex and personal experience for those experiencing it, and can be understood from a multitude of perspectives, such as psychiatric, legal, psychological, social and service user perspectives that embody discourses of expertise by experience. Such perspectives are taught within the AMHP educational curriculum. In the HIP a range of perspectives were contextually enacted by AMHPs to make sense of everyday practice. I define these as ‘perspectives in use’, to describe the multitude of perspectives that participants had a good applied understanding of but to stipulate it was what they *enacted* that
was important for their professional role and identities within the HIP. The idea of a ‘hybrid’ professional who works within mixed structures, such as health and social care organisations, included an understanding that such professionals commonly embrace a breadth of perspectives. This was witnessed in the ways participants integrated differing ideological stances situationally and contextually, as noted by Noordegraaf (2007, 2015) and Denis et al (2015). Differing (and possibly competing) perspectives enabled inter-professional working, and it was arguably the breadth of knowledge that gave participants as hybrid professionals scope and permission to cross professional boundaries.

‘Perspectives in use’ were contingently selected in practice events, based on repeated experiences that validated discursive actions. ‘Perspectives in use’ enabled participants to make sense of individual presentations of mental illness, facilitated an applied understanding of service users’ presentations, participants’ professional actions and served to guide their actions as professionals. They were ‘habits of thinking to which we become committed or emotionally attached’ (Sayer, 2011, pp.26-27). ‘Perspectives in use’ occurred in events, such as the MHAA, in an ongoing flow of activity. The perspectives enacted depended on the situations encountered dialogically within MHAA with other professionals. Perspectives were drawn from an inter-professional field of knowledge, and were key to how participants cross-cut boundaries into other traditional jurisdictions, illustrated by, but not confined to, Matthew’s view that the ‘role is quite generic really.’ The broad repertoire of ‘perspectives in use’ illustrated the ways professional relationships were navigated.

Each participant had a unique biography. This biography influenced the dominant ‘perspectives in use’. There was no single coherent perspective into which the complex presentations of mental illness could be neatly secured; as mentioned earlier, people’s lives
do not come in discipline-shaped boxes, nor can one single perspective offer a unifying understanding of such complexities. Rather, hybridised perspectives enabled participants to enact a range of perspectives contingently, linking back to William’s comment about being a ‘jack of all trades.’ These perspectives enabled participants to assess a person’s presentation holistically, through drawing on a variety of perspectives. So, although social perspectives across all participants’ data were the dominant ‘perspective in use’, followed by legal perspectives, participants cast alternative perspectives, such as medical/psychiatric into their everyday practices. The social perspectives, a jurisdictional claim of the AMHP role, was strongly featured in all participants’ enactment of their everyday practices, and featured examples of counteracting the impact of poverty, oppression and discrimination, seeking to mitigate where possible the devastating impact of mental disorder on individuals’ and family members’ lives. Legal perspectives were foregrounded by participants when legal duties required enacting (this was linked to the role of legal enforcer) and when acting as an advocate for service users’ rights, or to protect rights that could be breached, for example, by the bed managers, or other professionals, e.g. Bernie’s example of the nurse who unwittingly thought a female could be detained into hospital without a MHAA, not realising this would be in breach of her human rights. These perspectives in combination offered a powerful counter-critique to the overly medicalised model of risk assessment and risk management promoted predominantly by doctors and police officers. Social perspectives significantly offered an alternative to ‘them and ‘us’ thinking, visible in participants’ narratives, particularly in Simon’s and Matthew’s, who normalised their position of power and constructed mental disorder as situated within everyday lived experiences, rather than something to be pathologised. Interestingly, Simon, Matthew and Dawn as health AMHPs had equally strong social perspectives and described numerous ways in which they integrated their understanding of the social context of individuals’ situations. So, whilst participants
displayed considerable knowledge of medical/psychiatric perspectives and valued the
importance of medication and the resources attached to diagnosis, they used this knowledge
selectively. In these ways, participants enabled service users to express their distress in a way
that made sense to their identities, offering service users opportunity to reclaim some sense of
purpose over their lives.

‘Perspectives in use’ represented a subject stance towards a person, situation, in spaces and
places at specific times, revealing centripetal orientations, the internalising perspectives
through which meaning in and from external sources was selected (Holquist, 2002; Bebbington et al, 2007). These were the internalising perspectives which the self transmitted
towards others. They located my concept of ‘perspectives in use’ as an expression,
externalisation and enactment of professional identities as dialogical. The broad repertoire of
‘perspectives in use’ illustrated the ways AMHPs navigated professional relationships.

Working in an era of social and organisational instability, participants as hybrid types were
flexible and adaptive. This was witnessed in the authorial stance with other professionals
with whom they worked:

*I think everybody takes the lead from the AMHP and in some ways that can be a very
empowering place (Elizabeth, Interview 1, 01.10.14).*

The social perspective emphasised the importance of human rights, advocacy and acting for
service users’ best interests, and it revealed the interrelationships between social structure and
agency (Bourdieu, 1990). Sources of professional roles were based on multiple influences,
that were shaped and adapted by organisational and professional preferences in the
workplace. Identities conveyed repertoires, ‘perspective in use’, knowledge, skills and values
set by the professional. As Kate emphasised, perspectives are pluralistic; you bring all your
knowledge ‘to bear on the situation’ and contextual, ‘you apply it to that situation.’
*Heteroglossia* (Bakhtin, 1981) is a term used to signify language as ideologically saturated; a way of conceiving the world constituted by a ‘multiplicity of languages, each with its own formal markers...associated with it a set of distinctive values and presuppositions’ (Holquist, 2002, p.69). The myriad responses one might make at any one time are selected from specific discourses from the numerous ones available. Thus, the essence of psychiatric language is to be found in psychiatry, legal language in the law, and so on. I suggest hybridity was found where this language and perspectives were conjoined in professional discourses.

‘Perspectives in use’ were expressions of professional hybridisation because they revealed the multiple perspectives enacted that cross-cut other professional roles, and because they revealed a working culture through which participants practised their professionality, when they authored the world (Holquist, 2002). As Bakhtin (1981, p.280) states, ‘all language has the taste of a profession’. The language participants used was sometimes ‘borrowed’ from the various professional fields of practice, e.g.in Diana’s use of ‘patient’ rather than the social work term ‘service user’, or the use of the new word ‘customer’, reflecting the influence of managerialism. Drawing on hybrid perspectives revealed participants as hybrid professionals, because they crossed into other areas of knowledge and expertise (Noordegraaf, 2007).

Participants moved between and selected different discourses visible in their ‘perspectives in use’. In their dialogues, they fixed boundaries of their legal function and reflected power relations in their dialogical positioning with psychiatrists. In these ways, they occupied hybrid positions. By selecting language available from other professional cultures and by their choice of its arrangements, AMHPs made a positive claim to a certain vision of the world:
I think who's got like good SW values, is not afraid to, I'm not saying bring all your emotion into because you don't, but you've got to feel like empathy for them, and always put yourself in their position – 'what would you like to happen' to not forget that human side of things. To always want to do the best for someone and bring the best out of them... A good AMHP is all of that and the other people in the house, don't pretend you didn't see Billy in the corner, just because he's a child and you might have to do a safeguarding. You know what I mean see everything and the child says, 'I'm starving' and you think 'crumbs have they had anything to eat today'. It understands that these are real life things, aren't they? You can't just ignore them. Kids in poverty because of parents who have mental health problems, you can't just pretend you can't see it, just because you're on a mission to do something else – it's the whole picture isn't it. And not being afraid to challenge, because sometimes decisions are wrong. Not being afraid to challenge (Tina, Interview 1, 01.10.14).

Participants continually (re)authored to make meanings, because interactions were accomplished with an intentionality to bring forth something else; that is, events, outcomes, actions, perspectives, influences, cooperation via negotiation with other professionals connected to their values.

‘Perspectives in use’ were drawn from myriad available responses as signifiers of professional identities enacted in dialogue between participants and others through stories, where the medium of exchange was language. In such exchanges, it was words that fixed meanings. Words segmented experiences into meaningful patterns; they existed to register sameness and difference (Goffman, 1959; Jenkins, 2008), who we are and who we are not. It was not enough to simply understand the other professionals’ perspectives; ‘perspectives in use’ signified the multiplicity of voices in enacting identity positions. The idea of a single perspective is contestable; for example, there are social perspectives not one social perspective, although within this cultural genre there are commonalities that can be grouped together. The reason there was no single perspective and there are multiple voices was because language was ‘borrowed’ from others. One way of seeing will always illuminate some aspects and obscure others. ‘Perspectives in use’ were used for this purpose, to enact an understanding of an event from multiple standpoints. Any language used was mediated by the
social interaction, and these were often contested in ‘dialogic exchanges’ and subject to change and revision through addressivity (Bakhtin, 1981, 1990; Holquist, 2002; Beech, 2008). An active understanding of multiple perspectives incorporates others’ centrifugal orientations into one’s own frame, giving it new nuances. It was this very possibility of incorporating other perspectives that was hybridised, witnessed through dialogic exchanges incorporating other perspectives into one’s own centrifugal orientation, where participants learnt from other AMHPs and other professionals with whom they practise MHIA. Dialogue thereby oriented the perspective of the other (in the HIP psychiatrists, doctors, police officers, bed managers etc.), seeking to introduce new elements into it, where participants situated themselves in social interactions and related their own perspectives to those of others. It was a standpoint which made something new of the others’ perspectives by assimilating or not with one’s own ‘perspective in use’. In practice the benefits of externalising a ‘perspective in use’ was used to achieve a desired outcome by talking the language of other professional fields. In doing so, AMHPs showed they commanded respect and authority and other professionals accepted them as knowledgeable in these professional fields. This enabled boundaries to be crossed in other professional jurisdictions. Much of the language used by participants was intertextual, in that it referred to other statements and views in dialogic exchanges:

*A lot of the social workers are talking the talk, but not telling me anything about it. You know the house was dirty, they didn’t talk about any social care needs, didn’t talk about why the woman was tearing her hair out. It could have been that she just didn’t have any money or any means of getting through the day, they don’t talk about anything like that just what she presented like and she's not taking medication, that's all it was about, if she was concordant with the medication then that wouldn't have happened (she means that's what the student and would say) mmm... Not necessarily, I want people to see the broader aspects of assessment not just that tiny bit that they think makes all the difference (Tina, Interview 3, 20.10.15).*

However, not all ‘perspectives in use’ were equivalent. Bakhtin (1981) conceives there are dynamic interplays and interruption of perspectives taken to produce new realities and new
ways of seeing. Dialogic exchanges involved the interplay of values, which were applied within professional work. It was incommensurability that gave dialogue its power. It is necessary here to recognise that ‘answerability’ to the dialogue was dependent on how it was interpreted by the audience.

‘Perspectives in use’ can be understood in the context of dialogism’s addressivity. Addressivity means that I am an event, the event of constantly responding to utterances of the different worlds I pass through. In dialogue, participants express their responses to an event. What language they use, and how they use it, signified hybrid positions enacted in the event of addressivity. Hybridity showed the extent that participants embraced and enacted the other’s otherness; in this sense, the perspectives used that have cross-cut into other professionals’ traditional schemas for understanding mental health presentations. Meaning was shared in social experiences and was responded to. Such responses located the perspectives participants used as an aspect of their professional role and identities as hybridised; that was, ‘the different degrees each possesses of the others otherness’ (Holquist, 2002, p.51). It was defined in the professional perspectives (spoken in my data) that placed participants’ ‘perspectives in use’ along the dimensionalities of social, therapeutic, psychiatric and legal perspectives, fixing them at a time/place in dialogic exchanges with significant others, e.g. psychiatrists. How others also perceived and expressed their perceptions was significant, with Bernie’s example of a psychiatrist expressing as important her position of enacting her AMHP role ‘like a judge’. Dialogue enabled a mutual exploration of how participants saw themselves and how other professionals saw them. Dialogue found meaning through words, in a dialogic exchange. It was a way of thinking together, as there was much to be gained from understanding and listening to points of view that differed. In doing so, hybridity was visible at the points in an event when participants enacted the
language used from the others’ otherness and in enacting perspectives with the language normally associated with it. Identities of sameness and difference were illuminated in this way, similar to Goffman’s in and out-group dynamics (Goffman, 1959). Utterance was performed; it was active, it was a border phenomenon, taking place between people. It was soaked in social factors between what was said and unsaid, where values of professionals were shared. In ‘perspectives in use’, judgement on whatever information was contained in what was said was passed. Professional practice was structured around such events. Each time participants used perspectives they enacted their values through speech, scripting their place and that of the listener to a specific work event, and what they intended to accomplish in saying what was said.

7.2 Boundaries, collaboration and inter-professional work

Boundary spanning was an important finding in the HIP, as it mapped out the tensions involved in enacting roles and identities to reveal how the jostling between other professionals can be understood. AMHPs’ espoused identities featured claims for knowledge and what was unique as a means for exercising their legitimate control over work areas. They were considered legitimate by a broad range of workers because they possessed knowledge of the legal framework of the MHA (Department of Health, 2007). Boundary spanning was judged by various audiences during events. AMHPs operated at the intersection of several disciplines, signified through ‘borrowed’ language and interventions from various fields. In this study boundary spanning was interpreted through the negotiation, across boundaries, with participants filling the liminal spaces where other professionals refused to go. This negotiation was typified by the comment from an AMHP of ‘sweeping up the odds and ends’
in my previous study (Leah, 2013). Participants were often stuck in the middle, in liminal spaces of interagency partnerships that had differing and often competing priorities.

Boundary spanning across different organisations was typified by participants’ professional practice during MHAA, where their professional work was connected to multiple organisations, where AMHPs took the lead, particularly when enforcing adherence with duties under the MHA mediating between their own organisation and wider social structures (Department of Health, 1983, 2007); for example, when Bernie advised magistrates of their duties to provide her with a warrant, involving a gentle negotiation to correct their understanding of the law and secured a section 135 to enter a person’s property, or when Dawn described the intricacies of how the police department operated. This knowledge allowed her to plan for police attendance at MHAA; and in Elizabeth’s story of the ‘hottest day of year’, where she used her legal knowledge and persuasion in her communication with police officers. When she foregrounded her legal knowledge, she overcame several organisational barriers, to secure the safe conveyance of the individual to hospital. This was an exercise where Elizabeth enacted her knowledge of safe conveyancing in a clear manner, and in doing so she entered the practice territory of the police officers, correcting what they believed was the appropriate way of dealing with the situation. This demonstrated the ways that boundary spanning was both difficult and real and was enacted in spaces of interprofessional tensions and conflicts. Participants reconciled conflicting and divergent professional views, coordinated the collective professional group, and provided a means of connection through dialogism with other professionals in the best interest of the service user. Boundary spanning therefore became a way of articulating AMHP professional roles and identities at the intersection of these systems dialogically with other people.
However, unlike in Nissen’s study (2010), AMHPs did hold authority over others; for example, in the duty to request conveyance. But this did not extend to being able to enforce specific times, and was subject to many false starts and delays. Participants overcame this common occurrence dialogically, by using relational skills of friendly persuasion:

_I think about yourself as an individual your own interprofessional skills, your ability to adapt and change to settings you may find yourself in (Matthew, Interview 1, 13.01.15)._}

Adaptability to various settings was a key component of participants’ boundary spanning, with participants adapting to the environment and the people within it, in sophisticated ways. I consider adaptability a key component of AMHPs as boundary spanners, as it revealed a high degree of modification to the environment and a professional malleability. It required sophisticated relational skills to establish relationships that were close enough to enable an understanding of the often implicit concepts and meanings with which different professions and disciplines may approach a shared task, and separate enough to maintain a systems perspective (Bartel, 2001; Oliver, 2015). As boundary spanners, participants were adept at breaking down boundaries between themselves and others to build trust and appropriate care and treatment plans, within the context of managing risks.

Examples of facilitative leadership were revealed in the data in a number of interconnected ways, including marshalling the resources and deploying them strategically. The holistic, hybridised nature of the role was succinctly illuminated below and placed in stark contrast to the tightly defined parameters of a doctor’s role and remit:

_So, it's almost like a psychiatrist got a mission and it can't go to the left or the right, whereas an AMHP we are used to being rolled everywhere. And do everything. They can't do that thing we can multitask (Tina, Interview 3, 20.10.15)._}

This was interrelated with ironies in role enactment:

_But I’ve not been phoning the senior management to organise the transport, simply because it takes too long, and they don’t understand if I’m in somebody’s house and_
I’m doing an assessment and this person is particularly unwell. To waste time phoning a senior manager to phone an ambulance is very silly when I’m here and I can phone it myself and describe what’s going on. When the ambulance crew phone you and ask; ‘are they breathing, are they this and are they that?’ They can’t answer that question because they are not there, it’s silly (Tina, Interview 1, 01.10.14).

The excerpts above highlighted the contentious nature of boundary working and the conflicts that routinely occurred over scarce resources, such as beds. Although the MHA principles state that all duties must be proportionate and least restrictive of the person’s rights and freedoms under the Human Rights Act (Department of Health, 1998), AMHPs were acting as legal enforcers but were constrained. This played out in real ways, impacting on service users’ lives with Tina attempting to minimise the undesirable and potentially unlawful (discriminatory) effects dialogically with bed managers regarding lack of available hospital beds.

As boundary spanners, participants acted as buffers on the boundaries of practice, protecting service users’ best interests through the enactment of the multifarious roles, discussed in section 7.3. Participants responded on the boundaries of practice to other professionals who bring ambiguity or uncertainty with increased buffering to strengthen their professional boundaries and jurisdictions of practice. To operate effectively when power was dispersed across systems, participants needed ‘relational agency’ (Edwards, 2009). This response was present in participants’ ability to elicit and utilise individuals’ motivations and strengths to create plans that were responsive to, and made best use of, the wide range of perspectives and resources available. Participants delimited others’ professional agency in these encounters through pre-empting or correcting any action transgressing the limits of the favoured direction, often acting as an ‘agent of change’ (Nissen, 2010). Dealing with a high degree of risk was one salient aspect of how boundary spanners have been conceptualised (Williams,
2002; Kerson, 2004; Edwards, 2009), and AMHPs in this study demonstrated in numerous ways how they enacted a role as boundary spanners:

So, it’s about working with all, trying to work with their team but it takes an awful lot of energy trying to pull (it) back together, in having people to give you the time it does feel like you’re chasing them around far more (Elizabeth, Interview 1, 01.10.14).

Elizabeth cross-cuts team boundaries, navigating through improvisation and dialogue to resolve the inherent tensions of working across different organisational priorities and professional remits.

Participants encroached on other professionals’ ‘distinctive space(s)’ (Bourdieu, 1986). They appeared at the court room, in accident and emergency departments, in out-patient clinics, but the spaces belonged to magistrates, lawyers, doctors and nurses. Participants articulated their knowledge in the courtroom dialogically, as their knowledge was not taken for granted and involved a negotiated status with magistrates as bona fide professionals. They did so with aplomb; rather than retreat and seek the safety of a closed professional role and function, they rose to the challenges of complex organisational encounters and used their significant highly hybridised knowledge to dialogically achieve the outcome they desired. This was achieved in the spirit of collaborative and friendly persuasion.

Boundary working was intimately connected to moral values and political focus on social justice; on being able ‘to make the wheels turn’ so the service user did not get a ‘bum deal’, navigating pathways to make them more just and least damaging for service users. AMHPs acted as society’s safety net when they detained individuals against their will under section 2 and 3 of the Mental Health Act, under the ‘risk to others’ criteria (Department of Health, 2007). They reconciled conflicting and divergent professional views and coordinated the collective professional group, providing a means of connection and transition with GPs,
psychiatrists, ambulance crew and bed managers in the best interest of the service user
(AMHP Regulations, Department of Health, 2008).

Participants navigated multiple organisations and cross-cut these boundaries within a day’s work. Inevitably, when organisations changed policies and procedures, AMHPs got caught up in the cross-fire. As different organisations had different priorities, AMHPs were pressurised into adapting to meet other organisations’ priorities to safely and humanely detain individuals in hospital. Improvisation was key in how they navigated these conflicting priorities; it involved dealing with a high degree of both professional and personal risk:

Now they’re saying they want someone in the back of the van with them, so that was another layer and it was just one night of horror. I’d gone home and it had gone on and on and I’m on the phone to the AMHP – its 10 pm at night and in the end bed managers said; ‘go and get a taxi and leave your car in X (a dangerous place), you get in the back of the van, go all the way to the hospital in the dark and then go back in a taxi in your car. I thought this is just madness. She said no, she’s on her own, no. They’re insisting on that, if the paramedics who come are trained one will get in the back. Trained in restraint. They prefer someone else in the back with them, so they can make that difficult (Tina, Interview 1, 01.10.14).

Coordinating the assessments was an area of identity work that was both relational and dialogical. Using the word ‘orchestrating’ showed how William compared himself to the conductor of an orchestra, in that he set the pace, direction and focus of the MHAA. The work required one ‘conductor’ to ensure the process ran smoothly to achieve the best outcome for the service user:

Orchestrating the whole Mental Health Act assessment, it takes up a lot of communication skills and being assertive with different people, a lot of organisational skills, and the process to work it does need that one person to clarify the steps with everyone make sure that everyone is on board with things, so it does run smoothly and then you are able to do to achieve an outcome hopefully at the end of it that’s come from a very thorough discussion, where everyone’s understanding of what’s going on is there (Interview 1, 24.11.14).
Boundary working involved cross-cutting service areas with different professional groups, notably, psychiatrist, police officers and paramedics:

Thinking about it from a Mental Health Act assessment point of view may be easier; first of all, you are liaising with different agencies in mental health services or different professions in mental health services to start with. I suppose you would be talking to care coordinators which could be nurse, or occupational therapist generally and then you go from there, you would speak with the GP and a different psychiatrist who is on call maybe a section 12 Doctor. Then setting up the actual assessment you’d be looking at, maybe looking at support from paramedics or from the ambulance service or from the police as well. That tends to be the main focus really (Matthew, Interview 3, 03.11.15).

The dominant practice focus was on navigating across various organisational and professional groups, enacted dialogically as responses often differed from within the same professional groups; nothing was taken for granted. An example was conveyed of a police response to a request for a section 136:

I’ve found that it's not just the same response that you get from the police each time that you do 136, it can be varied depending on their pressures and their sergeant may be asking them to leave, do you need to be there when questioning the case, which is fair enough then has to be a rationale there, so it would be very much that you'd be weighing up, the situation and you be saying either; ‘Yep you’re fine to go, or this person is presenting this way, would you mind staying and helping us out. I guess it is ultimately up to them if they wish to go and that's up to them, we can only request that something that happens or doesn’t. I think we have more of a discussion put suggestions forward but we see what they say really (William, Interview 3, 03.11.15).

This involved a discussion by William of his professional remit, where he tried to get some understanding of the situation from the police’s perspective. In the excerpt, he traversed between an authoritative directive stance and a caring ethos. In doing so, he invoked different skills to highlight the differences in professionals’ remits and to manage the conflicts that resulted (Klein, 1990; Nissen, 2010).
7.21 Summary

In exploring boundary spanning, I have illustrated the dynamic enactment of the positioning and repositioning of participants’ work across professional and organisational boundaries. Participants worked across both integrated and dispersed systems, that involved the negotiation of both emotional and social processes inherent in interprofessional working (Cooper et al., 2017). Participants’ identities were dialogical when they enacted the AMHP role to address other professionals with whom they worked. Within working arrangements, participants were found to attach meaning to their professional jurisdiction, through speaking across, alongside and with a range of stakeholders.

My findings suggest that participants interacted with individuals, families, communities, other professionals and a variety of organisations as boundary spanning professionals. They routinely cross-cut systems, providing a means of connection for people in mental health crisis, and filled the liminal spaces left by other professionals. In doing so they engaged in dialogic exchanges with others; namely, psychiatrists, police officers and ambulance crews, doing whatever was necessary to secure the most dignified and humane intervention for people experiencing mental distress. There are clear benefits for AMHPs to be positioned as boundary spanners as boundary spanning offers those in the role a professional script from which to draw. This professional script could position AMHPs as boundary spanners negotiating dialogical professional identities. In these ways, boundary spanning is a core element of the AMHP role and is an interesting finding.
7.3 Hybrid roles

A hybrid professional straddles several professional roles and operates within broad knowledge areas (Noordegraaf, 2007; Nissen, 2010; Mc Givern et al, 2015; Blomgren and Waks, 2015). AMHPs’ roles were partially determined in this way. The HIP located additional invisible roles that AMHPs inhabited beyond the officially sanctioned role of the legal ‘applicant’. These roles were: ‘detective,’ ‘therapist’, ‘mediator’, ‘quasi-judge’ (and ‘jury’), ‘legal enforcer’ ‘custodian of social justice’ ‘advocate’, ‘educator’ ‘leader’ and ‘mediator’. These roles were adopted or imposed upon AMHPs whilst exercising their duties. It was evident that these multifarious roles displayed AMHPs as hybrid professionals. In my interpretation of hybrid roles, I have drawn on previous empirical and theoretical knowledge of the ASW role as multifarious (Quirk at el, 2000; Rapaport, 2006).

Annette discussed her reflection on the multiple roles she inhabited as a social worker and AMHP: ‘I suppose it's true that you slip into different roles all of the time and you use all of your knowledge and experience as a whole in everything you do’ (Interview 3, 13.11.15). The multiple roles AMHPs inhabited was also supported by Tina’s comment concerning the metaphor of ‘wearing different hats’ ...you’re the advocate, you’re the caring person, you’re the judge and I’m going to detain you, but I also care about you! (Tina, Interview 1, 01.10.14).

Tina suggested the AMHP role involved juggling different nested roles within the dynamics of a MHAA skilfully and sensitively: ‘Well today I will be wearing this hat, and then the next minute in the same day I’m wearing another hat’. The roles were improvised and interrelated,
with certain roles being more valued and socially desirable than others to AMHPs, service users and professionals who came within the orbit of MHAA:

*And you’re just juggling all these different roles all the time...so that always throws me a little bit that juggling of roles, So, it's not always clean cut what you do* (Tina, Interview 3, 20.10.15).

William stated he ‘wears many hats’ and through this metaphor he is indicating his salience with ideas of occupying hybrid professional roles.

This notion of multiple roles is examined below.

**‘Detective’**: Participants enacted a ‘detective’ role when they gathered written and verbal evidence before, during and following MHAA. This role included gathering medical evidence from section 12 doctors, GPs and psychiatrists, and social evidence from service users, carers, and other professionals involved in the individual’s care and support plan, and when they ‘interviewed’ relevant parties to understand individuals’ mental health presentations. Elizabeth succinctly conveyed the nature of the role below:

*You do weigh the evidence, and some of the evidence isn't great to be quite honest from other professionals, as well as being a judge also like a detective...(But) A lot of the evidence is not forthcoming really, so have to dig for the evidence, and you have to make sure you been thorough, going through records and asking questions when you think something's been missed, and it frequently is* (Interview 3, 03.12.15).

Additionally, as ‘detectives’ participants understood and reconciled contradictory information. Here, Elizabeth’s comment about certain professionals having a ‘*vested interest*’ was related to care coordinators and psychiatrists who requested service users’ hospital detention and communicated this information through a medicalised ‘lens’. The skill of participants was in ensuring the detection of the different ‘lenses’ that various parties involved in MHAA communicated, ensuring evidence was holistic, rather than one-dimensional.
Equally, when faced with inadequate information, participants acted as ‘detectives’; an example was given by Tina of waiting to assess a mentally ill male:

*I saw this man walk down the street and I thought no it’s him! I said to the doctor; ‘I think that’s him’. And his sisters phoning on the mobile and I said; ‘I know’, so we’re following down the road like detectives and I said I’m just going to phone the police, they should be here in two minutes, literally around the corner, so I said; ‘Okay he’s left but you can take him on 136 now’, let’s change our hats quickly* (Tina, Interview 3, 20.10.15).

Here Tina invoked the detective role. She discovered the male’s location and moved quickly to secure a MHAA with the police. This role was particularly significant for participants due to working in a climate where defensible decision-making was legally required and the consequences of not gathering evidence could lead to litigation. This litigation was present in a variety of case law judgements where AMHPs had omitted this important element of their work.

‘Therapist’: This role comprised a caring approach, in enactment, illustrated through the following narratives:

*I will use my therapeutic skills to gain more information, to see if I can in any way work on whatever is their issues are, advice, signposting, in a more informal way, as much as I've signed that pink paper and stuff at the end of the day they've still got things that need resolving* (Dawn, AMHP, Interview 3, 17.11.15).

It was often invoked in highly emotionally charged situations, to manage risk to self and others and to reduce the stress arising from the process of MHAA:

...depending on the situation if you've got somebody who is highly agitated but I think even then you can have a therapeutic effect definitely... using therapeutic rapport, the way that we communicate with people, some of the approaches we might use to help people to understand what's happening...I think using good interpersonal type counselling skills to give people the opportunity to ventilate ...that can feel therapeutic really...and I think we used CBT approaches and psychosocial interventions (Kate, Interview 3, 19.11.15).

The longer term recovery of service users was an integral aspect of this role, so although the MHAA is ‘horrendous’ as Annette described it, it was also ‘on some level... therapeutic even if it does end up in detention as well’ (William, Interview 3, 03.11.15). From a recovery
perspective, it was present in the ways participants offered alternatives to detention for individuals, educating people and giving people alternative options, encouraging engagement with service users to stay out of hospital, 'so it's therapy but broad' (Matthew, Interview 3, 03.11.15).

‘Quasi-Judge’: The notion of AMHPs occupying quasi-judicial roles was a feature of the literature (see Quirk et al, 2000; Gregor, 2010). In contrast to the conceptualisation of AMHPs as ‘mini courts on legs’ (Gregor, 2010), a more nuanced role was conveyed in the HIP, where participants traversed dualistic functions that encompassed care and control, where tensions between these dichotomies were enacted dialogically. This was more than a role participants perceived themselves to enact, as Kate stated:

...we're making judgements all the time obviously, the final judgement is what to do, but we're making judgements throughout the process starting at Mental Health Act assessment. How we can do it, how we can coordinate it, so making all these judgements throughout and the new final judgement about whether someone is detained or not...we obviously need to take into account, the previous judgements that have been handed down on a particular issue, ...we need to know the key bits of law other judgements been passed down about...so with the nearest relative you're very clear now you can't make an application until an hour before you've got to keep trying to contact the nearest relative. That influences and impacts upon your practice (Interview 3, 19.11.15).

Here Kate illustrated the legal aspect of her role. She made ‘mini judgements’ throughout her assessment with a final judgement made on whether she would detain or not the individual being assessed. She took this role further to describe that she took case law judgements into account, and then provided a recent example of how case law had changed the way that AMHPs must consult with a nearest relative in the ‘Enfield Judgement’ (TW v Enfield Borough Council, 2014). This piece of case law was also referred to by Dawn, who was facing repercussions from her organisation for failing to follow the requirements of the judgement. All participants told stories of why and how they provided legal advice and of their
command of legal frameworks to psychiatrists, section 12 doctors, GPs, police and ambulance crew. Role enactment was visible in the ways other professionals perceived the quasi-judicial role occupied by AMHPs. Previously, Bernie narrated how a psychiatrist perceived her ‘as the judge’; in the telling of the story, Bernie was incorporating this judicial aspect into her own professional role. She communicated this was how the doctor perceived her AMHP role, and she expressed the doctor’s way of perceiving the role in this way ‘is quite useful’:

...one doctor said to me, he sees the AMHP as being the judge and that the two doctors have got to persuade the AMHP to sort of settle on their side of the fence if you will. And I thought that’s quite useful that, because whether you’re the doctor, the person’s care coordinator or the AMHP, there’s a lot of persuading that has got to be done and whoever does the best persuading it’s about what the outcome is (Bernie, Interview 1, 10.11.14).

The AMHP role was perceived to be more complex than that of a judge, due to the ever-evolving situations of assessment and risk management where participants were making live judgements that required negotiation, often in complex highly emotionally charged and risky environments:

If I don't consult with your nearest relative you’re not the upholding your Article 8 but if you don't have a nearest relative I'm not upholding your Article 5 right. So, judges look at that if it goes to court, but we're doing that on a day-to-day basis and in practice we are making those decisions (Kate, Interview 3, 19.11.15).

The excerpt demonstrates AMHPs’ legal knowledge of the Human Rights Act (1998) and how the legal aspects of the role were an important part of participants’ professional practices. This was both disadvantageous and advantageous:

I think the purposes of the Human Rights Act we’re individual public authorities on way we carry out the role AMHP, that is quite a heavy burden really when you stop to think about in that way (Kate, Interview 3, 19.11.15).

And:

You are similar in the sense you weigh the evidence in your coming to a decision even though the recommendations from two doctors may feel like more than just evidence I suppose, it might feel a little bit weightier, a bit more persuasive, but still the ability
to just step back from there and weigh the situation, and think actually, yes, I do agree with that or not. I suppose judges’ role would perhaps do something very similar. Weigh up what’s presented before them, take the decision from there (William, Interview 3, 03.11.15).

Matthew related how the quasi-judicial role was nuanced, we ‘get it right from the mouth’, and how within this role AMHPs were making informed judgements, responding dialogically to various people within a MHAA, to make the ultimate decision regarding detention:

_But with the evidence judges are provided with that third-party, we've got our own ability to get it right from the mouth, you can build up in that environment there and then in that setting and pull on the information that you had before. Judges respectfully are in a controlled environment, we are looking out, there sitting still and listening. So, we've got a bit better ability to influence, make decisions more around informed decision-making. We've got a live situation, and we've got a better picture_ (Matthew, Interview 3, 03.11.15).

Similar to judges, AMHPs have autonomous civil law powers to detain people for long periods (in hospital) that are equivalent only to the criminal law powers of the judiciary. As AMHPs make decisions about detention autonomously, in their own name, they can be summoned to court in person (CSW Report, 2017). It was an interesting, although unsurprising, finding that participants enacted a quasi-legal role.

_‘Custodian of social justice’:_ The custodian role used advocacy skills and was related to the quasi-judicial role in its legal focus. However, it differed in the sense of AMHPs acting as a protector of individual human rights through social justice, rather than merely legal justice values. Social justice was distinguished from legal justice perspectives through its emphasis on understanding the impact of disadvantage on mentally unwell individuals, on acting proportionately and in a least restrictive way of an individual’s rights and freedoms under the HRA (1998). The role was associated with reinforcing the legal boundaries of the MHAA when other professionals attempted to transgress them, and in minimising the consequences that detention would have on individuals throughout their lives. Caring for people, protecting
individuals’ human rights and working with other professionals to ensure this was upheld was a core element of this role and was illustrated in the following ways:

_Obviously least restrictive is one of the core values of AMHPs of trying to care for people, of the care that they need that’s least restrictive of their rights and their freedoms. That's the key thing, you know those human rights, because we're going in sometimes with warrants, we've got to square the proportionality with that_ (Kate, Interview 1, 24.11.14).

And:

_(I said) On what grounds are you taking her to the ward? She’s come here for a day centre session and she’s not been detained, you don’t just take someone off the street to a ward_ (Bernie, Interview 1, 10.11.14).

_If you get requests for Mental Health Act assessment, do you understand what you’re actually asking for? You are asking to use quite powerful legislation here to take somebody out of their house, can we think about it a different way?_ (Matthew, Interview 1, 13.01.15).

Below, Tina recounted an event concerning a dispute with a psychiatrist who, on flimsy evidence, recommended detention. She described how she acted as a custodian for an individual who she thought was arbitrarily detained:

_But it is worth the battle because that stops (them) going in, because they don’t need to go in, but you’ve got to be able to stand up and say it, because if you don’t who’s gonna say it for them_ (Tina, Interview 1, 01.10.14).

The seriousness attached by participants of enacting the custodian of social justice role, as a nested aspect of the AMHP role, was illustrated by all participants’ narratives. Simon’s narrative below was chosen as a typical illustration of this role:

_Because you make decisions about people's liberty really, you’re making decisions and you’re trying to do it by acting in their best interest, least restrictive ways you know what can work_ (Simon, Interview 3, 03.11.15).

Participants responded to the needs of vulnerable and diverse populations whose human rights were threatened by social and health inequalities, and redressed this where possible. This is part of the AMHP competency framework to ‘redress discrimination’ (HCPC, 2013).
However, their work was constrained by structural systems. Service users with serious mental health needs have poorer physical health, live in poverty, in poor housing, must wait or travel far to access a bed when in acute need, be unemployed or socially isolated and (to) die earlier (Marmott Review, 2010). This knowledge was applied when considering the impact of detention. In this role, participants made critical decisions about the least restrictive and most suitable context in which people should receive care and treatment, playing an essential, statutory role, in protecting people’s human rights by promoting the principles of the Mental Health Act Code of Practice (Department of Health, 2015).

‘Advocate’: Related to the custodian role was the advocate role, enacted when representing the view of the service user rather than to act as a protector of social and legal justice with other professionals. This role was principally invoked to support counter arguments to compulsory detention and to support individuals to express their views and wishes, ensuring their voice was heard and attended to, especially so for individuals with an inability to advocate for themselves, such as those who lacked mental capacity to make decisions:

I enjoy being the voice of people those who have no, no voice all or don't know how to articulate what they think, feel they been submerged by professionals, I enjoy that, I enjoy going toe to toe...We are paid to make it matter otherwise we should go into another job, and if you can't do that, we can't stand up for the people, making it matter and bring about change and do the difficult stuff and walk in the shit, then we should walk away (Annette, Interview 2, 11.05.15).

Here Annette conveyed her passion for ‘making it’ matter and how this was a significant aspect of her and other AMHPs’ roles. In discussing AMHPs who cannot ‘bring about change’ (albeit recognising this was difficult and they should ‘walk way’), she was narrating a discourse of AMHP practice as intimately bound to the advocate role.

Evidence of minimising the power differentials between doctors and patients during
MHAA was enacted in the advocacy role. Elizabeth, for example, discussed her enactment of the role to mitigate against the social exclusion of mentally disordered individuals, using an example of a female with a severe learning disability, where she tried ‘to advocate for her in the system whereby everybody has a criteria that seems to exclude rather than include’ (Elizabeth, Interview 2, 21.04.14). Dawn also suggested the advocate role was a strong element of her professional role, and stated ‘I’m going to give them attention, and devotion to get them to wherever it is they want to be, to stay where they are because they’re happy, whatever it is, advocating for them supporting them...that’s what I do in my work’ (Dawn, Interview 1, 17.11.14). Here the use of the word ‘devotion’ emphasises that advocating was a means of enacting and expressing her professional care towards mentally unwell individuals in similar ways to Annette. This was echoed by Tina and Kate:

I think it comes back again to making sure that people got some kind of voice that they can speak, that they’re being listened to and being heard because sometimes that can get lost can’t it (Tina, Interview 2, 20.04.15).

And:

AMHP is in a very strong position to advocate for the service user, and the importance of having a very rights-based or human rights-based approach (Kate, Interview 2, 01.07.15).

The advocate role incorporated a service user led focus promoting the service users’ perspective of the situation, ensuring that service users were listened to and that their voice was valued within the assessment process.

‘Educator’: The role of an educator was foregrounded when AMHPs educated other professionals to acquire knowledge and legal literacy of the MHA, its related regulations and code of practice. The educator role was invoked to make MHAAs run smoothly. AMHPs routinely provided advice to psychiatrists, police and ambulance personnel, advising on their applicant role and the power and duties invested in that. They enacted the educator role when
other professionals transgressed legally codified boundaries of professionals’ responsibilities, such as with bed managers when advising them of the delegated legal duty to provide a hospital bed and in persuading them of the detrimental impact of an individual’s admission to a remote hospital bed away from family and friends; ‘a lot of it is about helping them (other professionals) to understand our role’ (Kate, Interview 3, 19.11.15). It was invoked with GPs when AMHPs advised GPs of the grounds of mental disorder under section 1 MHA 1983 and on how to complete a medical recommendation. Elizabeth’s example illustrated the role below:

So yeah, we work with GPs and a lot of our role is actually guiding GPs, because mental health isn’t their thing for a lot of them. We do find ourselves in a guiding role…. drawing them back in and making sure they understand the process, because I don’t think even they have very much training on mental health, so I’ll have that discussion with them, and also making sure that they also know what other service provision are available, particularly when we’re looking at least restrictive (Elizabeth, Interview 3, 03.12.15).

As other professionals did not have a thorough understanding of the MHA, participants routinely educated others on the legal criteria and used this knowledge to reinforce legal boundaries. When psychiatrists attempted to transgress them, ‘You can turn around and say, ‘you gone far enough…case law says this’ (Annette, Interview 1, 17.11.14).

And:

I'm finding that the knowledge base of other professionals is quite lacking really, I don't think people have got the relevant training. I'd say with the ambulance personnel …why we’re choosing that section, because that's what they will ask when we are requesting an ambulance, what section is somebody been detained on (Elizabeth, Interview 1, 01.10.14).

The educator role was requested by nurses and occupational therapists, when they wished to discuss care and treatment options prior to making requests for MHAA. Tina stated:

I think they're becoming more knowledgeable about the AMHP role and they want to know what you can do, if you can do and how we can manage this…they’ll phone you up for a lot of advice in-between not just on AMHP duty. Just for advice. Act as an advisor, point people in the right direction (Tina, Interview 1, 01.10.14).
This aspect of participants’ working practice as educators has not been found previously either theoretically or empirically.

‘Legal enforcer’: A legal enforcer compels observance of or compliance with law. AMHPs routinely enforced the law, providing robust justification for legal actions and taking an authoritative stance in the face of the dubious practices of some psychiatrists:

Yes, I think we enforce law, we enforce order, we tell people what they can and can't do. We can force our way into your home, very much so, and we’re very much seen in that way and I'm not surprised (Annette, Interview 3,13.11.15).

And:

It does tend to be a similar role in terms of the authoritative stance where people perceive the police as we are an authority, and I suppose you’re trying to convey a message sometimes actually this needs to, they need to go into hospital you need to detain and whatever, you have to switch from very caring sympathetic typical social work values type feeling to actually get to a point where this is what we need to do, and just be very factual about things (William, Interview 3, 03.11.115).

Matthew discussed the situation below in two interviews, where a GP receptionist refused to access a GP for a requested MHAA. When she became increasingly obstructive, it resulted in Matthew invoking the role of a legal enforcer as follows:

I said you better listen very carefully to what I'm going to say to you now, ‘I feel that you're obstructing me in my duty and I will be taking this further, please go away and get me a GP’. And they had one within 10 seconds. It's the only time I've done it but again you have to do it (Matthew, Interview 3, 13.01.2015).

The legal enforcer role was an instrumental one. It involved discussing the legal duties of the AMHP role with other professionals and involved parties. It focused on promoting people’s rights, fair care and treatment support from health professionals who have a duty of care for their patients, and should not discriminate by not responding appropriately to requests for medical assessment. It was a holistic role that ensured people’s wider social circumstances were addressed and that the family and other relevant parties were actively consulted and involved in care, support and treatment plans.
‘Leader’: Within the data acting as leader was an emergent theme. The role of the AMHP was one of a key decision maker. Once the two medical recommendations were in place, the AMHP was required to either make an application for detention or arrange for suitable care and treatment alternatives to be sourced (Section 13, MHA, 2007).

Most definitions of leadership identity reflect the assumption that leadership is a social activity, where one person or group exerts influence over other people or groups to structure the activities and relationships in groups or organisations (Yukl, 2002, cited in Bush and Glover, 2003, p.4). Effective leadership was often closely linked to institutional effectiveness (Bush and Glover 2003). The notion of leadership in the context of management models described by Bush and Glover (2003) was not particularly appropriate for understanding of the AMHPs’ role as a leader, as AMHP leadership was centred on their unique position of operation within the MHA 1983. Within this, the AMHPs are uniquely professionally accountable for all legal actions; this autonomy sits outside the management remit (s.13, MHA 2007). Senge (1990, p.87), however, proposes a different idea of leaders as ‘special people who set the direction, make key decisions and energise the troops’. AMHP responsibility for the coordination of the Mental Health Act assessment resonates with this notion of an active leader. As strategic organisers of the all elements that are required during a MHAA, they took on numerous complex tasks and responsibilities. This involved gathering background information, speaking to parties involved in the care support and treatment plan if known, arranging the community assessment with psychiatrists, section 12 doctors, ambulance crews and police officers, effectively managing the crisis of the service user and the impact on the family, and making all the necessary arrangements for care, such as securing property, pets and ensuring children are cared for when necessary.
They commonly acted as advisors (in the educator role) to the police and ambulance crews on legal matters concerning the conveyance (transport of the service user to hospital), demonstrating a leadership function. When AMHPs intervened in the advisor role they showed professional leadership in situations characterised by high levels of social, family and interpersonal complexity, the management of risk and ambiguity was an aspect of the AMHP leadership role.

‘Mediator’: Examples of professional mediation took place across multiple agencies and professional groups. It involved persuading professionals who expressed disagreement with participants in their AMHP role to reach an agreement regarding the outcome of the MHAA. The role was invoked to assist disputing parties to resolve conflict using specialised communication and negotiation techniques. Participants as mediators used a wide variety of techniques to guide the process in a constructive direction and to help to find an appropriate outcome to MHA work. Participants managed interaction between parties (in similar ways to the ‘stage manager’ role in Quirk et al, 2000), and facilitated sensitive communication that respected the private and confidential nature of their work. Participants acted as sophisticated communicators in guiding other professionals through the process, characterised by broadening the range of possible solutions and the respectful way this should be achieved. They used various techniques such as dialogue and empathy, aiming to smooth the assessment process to secure the best outcome for service users, to make the bridges between different professional and organisational boundaries work productively:

*I think the role from me is one of mediator, very much so and I think across the different organisations because sometimes you mediate professional responses. Sometimes you soften the responses between organisations to make those bridges work better. Because you know you can get that kind of Mexican standoff almost, can't you between some organisations? (Annette, Interview 3, 13.11.15).*

And:
I think my job is about navigating some of those pathways to make it a little bit more just, to balance those roads a bit more because of being fair and that's what I see my job as being (Annette, Interview 2, 11.05.15).

Much depended on the mediator's relational skills; it was not a neutral activity, it was values-laden for participants enacted through dialogic exchanges within this role to ‘make(s) the wheel turn.’ It enabled the system to work better for AMHPs as boundary spanning professionals.

**7.4 Summary of roles**

The multifarious roles illuminated in the HIP illustrate the complexities of participants’ professional roles and identity enactment. The nested roles suggest participants practise as hybrid professionals, as hybrid professionals have been found elsewhere to straddle multifarious roles (Hoff, 2000; McGivern et al, 2015). Participants practised role adequacy; they were knowledgeable about their work and role legitimacy, believing they had the right to address certain issues, driven by values of social and legal justice. This perceived right gave them power and leadership, although the degree of this varied depending on the enabling and constraining contexts of professional practice, and the relationships between others they worked with. The roles discussed were nested within the formally regulated legal role of the AMHP. They showed through complexity in working arrangements within and across AMHP jurisdictional boundaries how roles were foregrounded events, with some roles filling the spaces left vacant by other professional groups through liminality. Dialogic exchanges were the mechanism for role enactment and showed how hybridisation occurred in the conversations that took place with other key workers, service users and family members, and what those conversations sought to achieve in terms of care and treatment outcomes and how they were achieved. The roles were relational, situated and constructed through addressivity.
They enabled participants to cross-cut professional and organisational boundaries to make the system work better. Enactment of roles was therefore a type of boundary spanning in the HIP, and suggests AMHPs can be conceptualised as hybrid professionals.

7.5 Ironies of adaption and ironies of representation-Ironic dialogism?

Participants’ professional roles and identities were revealed in their everyday discursive practices, and were enacted through ‘ironies of adaption’ and ‘ironies of representation’ (Hoyle and Wallace 2007, pp.18-19). ‘Ironies of representation’ were illuminated when participants presented an image of the organisation to the outside world, including other professionals involved in MHAA, that was incongruent with the reality of its daily practices. Irony was inevitable because the ‘official’ versions of professionalism and the AMHP professional role as the legal applicants was predicated upon professionally related behaviour the HIP revealed was inviable, thus, such notions of professionalism, in representing something that was inviable; careered towards nonsense. Ironies meant that participants worked under conditions that did not make sense but which they had to follow, despite their disagreement with them.

‘Ironies of adaption’ were found in the improvisation and negotiation of participants’ expectations to better meet the perceived needs of service users in contingent circumstances. The imperfect practice situations encountered by participants involved navigating practice complexities, often using improvisation:

*We had an assessment the other day, the bed was in X and the AMHP argued and said: ‘I refuse to take this patient who is psychotic all the way to X and we we’re given a round of applause, because there’s no way, in the back of the van, all the stops you’d have to make, for somebody that’s really poorly. How would the family see them Caroline? They’d never, in the middle of nowhere. A six-foot tall ethnic minority group, in the middle of X with no family, friends or contact. It begs the*
question of whether the human rights are being breached here or not! It’s like borderline that innit?! The thing is the bed suddenly became available in..., and it’s like; ‘Did you have that bed all the time?’ Why put people through that, and if the AMHP hadn’t argued that’s where he would have gone (Tina, Interview 1, 01.10.14).

Through enacting what they wanted to achieve, participants shaped their professionalities and their positions as a professional within it, both individually and collectively as part of a professional culture:

_I think it’s a very, closed, unless you’re an AMHP, I don’t think people have a got a good understanding and that’s like people, community psychologists, psychiatrists. Like even a consultant on Friday, I was sat in the car with him and a section 12 doctor, and he said, ‘So what will happen now?’ and I thought, ‘yeah, you haven’t got a clue what will happen now. I’ve got to get this chap to hospital, I’ve got to ring an ambulance, I’ve got to negotiate and I’ve got to make sure that’s there’s a bed, and he said; it might take 2 or 3 hours! What will you do? And I said, I’ll be in there, I’ll be in there!’ and he was like, ‘really!!!’ (Bernie, Interview 1, 10.01.14)._

Participants were caught between aspirations for delivering a socially orientated approach for the care and treatment of mentally unwell individuals, a legal role as an ‘agent of the state’, and bureaucratic and socioeconomic constraints, as ‘street level bureaucrats’ (Lipsky, 1980). These multifarious roles were visible in ‘ironies of representation’ and ‘ironies of adaption’. My interpretation of data revealed ironies were often a pragmatic response to the inherent constraints on practice, experienced by participants when they felt a disconnection between their values, role definition and the constraints on resources. Ironies were signified by the disjuncture between the officially sanctioned practices and the espoused practices of participants, suggested in Tina’s example:

_If I’m in a house why am I phoning you, to phone an ambulance when I can phone it myself? (Tina, Interview 1, 10.11.14)._  

The complexity of participants’ work placed a premium on professional judgment guided by knowledge, skills and values exercised in contingent circumstances, with ironies of adaptation reflected in two forms of power; AMHP authority as the ‘legal enforcer’ of a decision to detain, and their role as a ‘mediator’ when they used expertise and persuasion to
pull together the resources for detention or community alternatives. These forms of power involved collaboration, a term I used to denote the patterns of professional interaction which emerged from daily practice with other professionals. Collaboration was both a burden and a blessing. It was a blessing when working together with doctors for the best outcome for service users’ care and treatment in partnership, or a burden when managing contradictions in the organisational system they worked within, navigating ironies, particularly around bed availability. For example, when Dawn stated that she needed a code to obtain a bed and to obtain the code she needed to contact a bed manager, the bed manager was not available, so the code could not be obtained. Consequently, she was unable to find a bed for several hours to admit the service user to hospital, requiring her to adapt her role to one of ‘mediator’ and ‘advocate’. This was an example of an ‘irony of adaptation’ occurring in the middle of managing a complex MHAA (Hoyle and Wallace, 2007).

Ironies were illuminated by the lack of alternatives to hospital detention, as participants could not implement alternative care and support plans when resources did not exist. Examples of being sent on a ‘fool’s errand’ (Willis, 2000, in Holland and Lave, 2000, p.12) was a significant feature of AMHP work, particularly with bed managers, police officers and ambulance crews when arranging conveyance, but also when psychiatrists left medical recommendations, as Tina notes:

*If the RC has completed their medical recommendations we’ve got to go and get it from wherever they’ve left it, which is time wasting. Or ask them to fax it, to let the other doctor have a read of it, and then get another AMHP to go and get it and join us at the location (Interview 1, 01.10.14).*

And:

*Again, your role becomes diluted doesn't it, by the constraints of the system in which you’re working. You just forced to make changes because I know those changes… There's just not enough resources, so they change the law so it kind of fits better with their own system (Dawn, Interview, 3, 17.11.15).*

Alternative care and treatment support in the community was extremely limited; even the
traditional use of crisis and home treatment services was under considerable constraint and pressure and therefore was often not a viable alternative to hospital detention, and the availability of suitable beds was problematic:

To waste time phoning a senior manager to phone an ambulance is very silly when I’m here and I can phone it myself and describe what’s going on. When the ambulance crew phone you and ask; ‘are they breathing, are they this and are they that?’ They can’t answer that question because they are not there, it’s silly (Tina, Interview 1, 01.10.14)

This resource gap inevitably created paradoxes in the role as the legal duty, e.g. to look for least restrictive options is unavailable. Services were not always service user led; this was the experienced tension of boundary working. While participants prioritised service users, it was suggested by participants that other professionals, e.g. psychiatrists and police officers and organisations placed their own priorities and objectives first, causing increased tension when AMHPs attempted to exercise their statutory duties within the role:

I mean even when you try to get a bed, I mean that’s the biggest bind...Something as simple as that you’d think, we’ve got to go through that many hoops and the people you’ve got to speak to now, you’ve got to speak to higher people, to arrange it for you (Tina, Interview 1, 01.10.14).

There were ironies between care and treatment provisions, arising from policy imperatives such as New Ways of Working (Hope, 2005) and the Five Year Forward view (NHS England, 2014) and MHA code of practice (Department of Health, 2008) guidance and the realities of securing appropriate responses:

If the RC has completed their medical recommendations we’ve got to go and get it from wherever they’ve left it, which is time wasting. Or ask them to fax it, to let the other doctor have a read of it, and then get another AMHP to go and get it and join us at the location. That’s a lot of timewasting, and to me if they know them, it’s nice to have a conversation, so we always have to phone them after that and make sure we’ve had a conversation with them, because it is a 3 (section 3 treatment plan), put a treatment plan on there and we need to discuss it (Tina, Interview, 01.10.14).

Uncertainty about how psychiatrists would respond to their MHA duties was characterised by participants (to some extent) as the result of deliberate acts, sanctified by organisations, where such actions remain unchecked. In keeping responses to MHAA flexible and
uncertain, not knowing if the psychiatrist would do a joint assessment or leave ‘papers’ at a location to be collected, professional groups were fragmented. Hybridity then became a means of managing fragmented responses, as liminal spaces that were left unoccupied needed to be occupied, and were occupied by the participants, who had a duty to respond, but did so by recognising the irony of the practice situation:

So, the RC has seen them on a HV (home visit) and thought, ‘Right they need to come in’ and left it wherever...It’s brilliant practice to jointly assess, isn’t it, you can’t beat that when you’ve got everybody in the room and have a proper discussion not feeling rushed and raced along, just reading somebody else’s bit of paper, and I think if I was in somebody else’s place and I was poorly I think I’d like someone to sit and discuss taking away my liberty in a proper format not just let it be, ‘you go along and sign it’ (Tina, Interview 1, 01.10.14).

The seriousness of removing someone’s liberty as a paper exercise was commented upon by Tina, who used irony to make sense of the hypocrisy of the situation. Irony flowed from the dilemmas enacted in practice to achieve desired outcomes; irony signified the gap between professional intention and practice outcome (Hoyle and Wallace, 2007).

Ironic dialogism was a term I applied to interpret the disjuncture between the officially sanctioned practices and situated improvised practice; how participants improvised to achieve a desired outcome in their practice encounters with others and what they negotiated in certain marginal fields of activity not formally regulated by the state or their organisation.

AMHPs inhabited a twilight zone, located in places and spaces between a multitude of organisations, often stuck in the middle of interagency partnerships that have different (and often competing) priorities:

We had a nurse who shadowed a MHAA and in our team meeting he said, ‘Can I just say, I’ve been a nurse, I’ve worked on the wards, I’ve been a senior nurse in the community and for 10 years and I had no idea what it entailed and what a difficult day it would have been.’ So just think, well the AMHP will go out and the next thing, this persons in hospital. So, they don’t see what goes on and the negotiating you’ve got to do, managing situations, like I don’t really want to go at 3.30pm because her
kids will be coming home. And it’s like, ‘Oh right, oh yeah, okay... you know it just doesn’t sound like a big deal that but its massive, it’s a big deal. You know there’s seven police cars outside this person’s house and the kids come home (Bernie, Interview 1, 10.04.14)

Complexity and uncertainty in AMHP practice were both contingent and, to some extent, as mentioned above, the result of wilful acts. By keeping everything loose, organisations kept professional groups fragmented. This fragmentation was visible in the situation of both finding beds and conveyance to a bed, where the ‘rule book’ was indeed broken. Therefore, boundary spanning was a ploy by participants to manage fragmentation brought on by ‘ironies of adaptation’ (Hoyle and Wallace, 2007). Inevitably, when organisations changed their policies and procedures, participants were caught up in the cross fire of changes to the ‘rules of the game.’ As different organisations have different priorities, participants were pressurised into adapting to meet other priorities to safely and humanely detain a person in hospital. Improvisation was key in how they navigated conflicting priorities. This improvisation involved dealing with a high degree of both professional and personal risk:

Now they’re saying they want someone in the back of the van with them, so that was another layer and it was just one night of horror. I’d gone home and it had gone on and on and I’m on the phone to the AMHP – its 10 pm at night and in the end bed managers said; ‘go and get a taxi and leave your car in X (a dangerous place), you get in the back of the van, go all the way to the hospital in the dark and then go back in a taxi in your car. I thought this is just madness (Elizabeth, Interview 1, 01.10.14).

Elizabeth related the contentious nature of boundary working and the conflicts that routinely occurred over scarce resources, such as beds above. It was ironic that Elizabeth, as a competent professional with skills in managing risk, was advised by a bed manager to put her own personal safety at risk.

Although the Mental Health Act principles state that all duties must be proportionate and least restrictive of the person’s rights and freedoms under the Human Rights Act (1998), participants acted as legal enforcers but were constrained by organisational imperatives.
These imperatives played out in real ways that impacted on AMHP practice and service users’ lives. This was prominent in the tensions experienced in securing conveyance to hospital and hospital beds. Below, Diana described her frustrations in obtaining a bed:

...goes to the person who manages bed management, and if you can get hold of her...she’s on holiday and all the other people were on holiday (Diana, Interview 3, 06.11.15).

The irony was striking here; Diana was trying to negotiate for a bed to be made available from a bed management team that is neither available (and therefore not managing anyone) and seemed unconcerned that Diana was waiting at a mentally unwell individual’s house to take him/her to hospital. Instead of delivering quality care and treatment, participants narrated examples of ironically enacting that which they were opposed to. Policy and legal duties were reinterpreted by participants in the HIP who enacted them contingently, so that some aspects of ironic dialogism, such as bed management, had little resemblance to formal procedures. By drawing on ‘perspectives in use’, professionals exercised agency to achieve desired outcomes, underpinned by their knowledge of how practice outcomes were subject to constraining or enabling factors. ‘Ironic dialogism’ was apparent where participants devised methods through negotiated dialogue that gave the appearance of cooperation; it was a ‘cloak of conformity’ (Edgerton, 1967), involving bending of the ‘rules’. Conformity was disguised, so that participants could achieve the outcomes that were important to them, based on social values that were informed by the best interests of services users. This reinterpretation of ‘ironies of representation’ suggests AMHPs have found working practice strategies that enable their work to be managed despite competing professional priorities.
7. 6 Dialogic identities

In dialogue, it is words that fix meaning; they mark distinctions and segment experiences into meaningful patterns. Language is a matter of sameness and difference, and values can distinguish professional similarities and difference to make sense of events (Bakhtin, 1981; Jenkins, 2008). The concept of ‘transgredience’ in dialogism exploits the nature of language as a modelling system for the nature of existence (Bakhtin, 1981; Holquist, 2002). When we perceive the world through time/space of the self and through the time/space of the other, the difference between the two is a relation of otherness that can be gauged by differing professional positions of outsideness that are enacted as varying degrees of transgredience (p.35, Holquist, 2002). Participants authored a version of the event of a joint existence from their unique place in it by means of combining things they saw which were different (in addition to) those others saw, and the things they saw which are different from (in addition) to that difference. It is a form of architectonics, a ‘science of relations’; a relation(ship) is always in the process of being made or unmade (Holquist, 2002). It is also a narrative. Dialogism is authoring; in sharing an event we cannot choose not to be in dialogue, the world addresses us and we respond and are answerable. Dialogism recognises the multiplicity in human perception and experience. The multiplicity manifests through a series of distinctions appropriate to the perceiver and to whatever is being perceived; the world is an activity, and comes to us as an event.

Participants enacted dialogism to create plans that were responsive to, and made best use of, the wide range of perspectives and resources available, using dialogic exchanges to establish understanding of the often implicit concepts and meanings within which different professions approached a shared task:
...then we had a chance to have a dialogue about what's happening, and it's not usually something that happens overnight it's due to a build-up and then ... we can advise people to say, look at least restrictive before we go down that route, so it's probably a more fluid way of actually coming to the decision that we need to go down Mental Health Act assessment with psychiatrist (William, Interview 1, 24.11.14).

Participants placed themselves in situations they saw others as enacting. Dialogue was a manifold phenomenon, but for schematic purposes it was reduced to a minimum of three elements: it was composed of an utterance, a reply and a relationship between the two. It was the relationship on which differences, while remaining different, serve as the building blocks of simultaneity that was important. In a conversation both speakers are different from each other and the utterances each makes is always different from the other’s, even if they used the same word, yet these are all held together in the relation of dialogue. There are idiosyncratic features of the speaker, and features shared with others in language. Identities are both the enactment of and the externalisation of dialogical exchanges; dialogism was a process of interactive story telling of joint events. The enactment of professional identities involved a combination of participants telling their own stories of their own events and being written into others’ events by through heteroglossia (Bakhtin, 1981, 1990; Holquist, 2002).

7.7 Summary - links between hybridity and dialogism

These findings could contribute to recommendations for AMHP education and practice. AMHPs are expected to work with a huge array of colleagues, internal and external to their organisation, in spaces and places that are both familiar and foreign. The enactment of their roles and identities was impacted through the interface of multiple professional boundaries in liminal spaces.
It was problematic to consider only pure models of professionalism, because they did not fully engage with the changing contexts in which professionalism was enacted and in which professional identities were espoused. In the context of AMHP professional roles this was particularly complex. Participants were subject to numerous professional, managerial and organisational interferences. They were subject to management structures from within their own organisations and were also structured by outside organisations which they relied upon to undertake their work. This feature of professional work has been especially noted in professional services that are organised between the state, society and professionals (Noordegraaf, 2015). Dialogism brings meaning and explanation to the AMHP role and participants’ professional identities. Dialogic identities are a means of enacting types of hybridisation, located within centripetal, centrifugal expressions and through the expanse of hetroglossia, pinpointing participants’ professional role(s) as a hybrid professionals.
Chapter Eight

Conclusion

8.0 Introduction

This concluding chapter is structured as follows. Firstly, I summarise my key findings through addressing the research questions, linked to my final elaborated and developed conceptual framework presented below in Figure 8.1. This is followed by a discussion of my contribution to the field, then a consideration of future research areas, and finally, researcher reflexivity.

Figure 8.1 Final conceptual framework of hybrid professionals and dialogic identities
8.2 Elaborating on the conceptual framework and summary of key findings

The HIP, which generated data from ten multi-professional AMHPs across three sites, set out to address the following research questions:

1. What is the role of the AMHP and how can AMHP professional identities be understood?
2. What is a hybrid professional and in what ways is it appropriate to conceptualise AMHPs as hybrid professionals?
3. What recommendations can be made regarding the use of hybrid professional roles and AMHP professional identities in the recruitment, training and practice development of AMHPs?

Several interrelated concepts have been identified from emergent theorising and empirical data. These concepts act as a ‘superstructure’ for theorising AMHPs’ professional identities as dialogically negotiated through hybrid professionalities. These concepts are illustrated in the conceptual framework presented in Figure 8.1. Aspects of AMHP hybridisation were illustrated within the hybrid dimensionality discussed in chapter 6 of the project, amongst ‘perspectives in use’, hybrid roles and boundary spanning, located at the bottom of figure 8.1. ‘Perspectives in use’ revealed that AMHPs enacted a range of ideological stances drawn from other professional knowledge areas. These were legal, psychiatric and therapeutic, and their own jurisdictional claim over social perspectives. They located AMHPs as particular hybrid types (SLP, PSL or TSL hybrids).

Language was found to be ‘borrowed’ from various professional fields. Heteroglossia, (Bakhtin, 1981) a term signifying the ideologically saturated nature of language, is a key concept within dialogism, in the way ‘perspectives in use’ is a key concept within hybridity,
with both concepts indicating adopted professional ideological positions and the enactment of those positions. These interlinked concepts marry hybridity with dialogism, because both concepts show how language positions professionals and their professionalities, and they locate how professional roles and identities could be enacted. They revealed how participants selected language contextually with different professionals cross-cutting various fields of professional practice to negotiate outcomes in care and treatment provision. The multitude of situated dialogical exchanges that occurred in professional contexts showed participants’ authorial enterprises as an internalisation and externalisation of the ordering ability of language amongst the complexities of coordinating MHAA, through centripetal and centrifugal concepts (Bakhtin, 1981; Holquist, 2002). ‘Perspectives in use’ enacted contextually and situationally enabled participants to boundary-cross into other professionals’ practice jurisdictions and to claim hybridity, because participants were found to operate within broad knowledge areas, with competence developed outside of their main areas of expertise. The enactment of broad knowledge areas, traversing multifarious professional roles and jurisdictions via dialogic exchanges where language was borrowed from various professional fields, was a key aspect of participants’ professional roles. It is suggested that AMHPs are hybrid professionals, as hybrid professionalism involves the enactment by professionals of competence outside their main area of expertise to cope with a variety of organisational requirements (Noordegraaf, 2007). In the public sector, the concept of hybridisation has been utilised to illustrate the professional implications of professional and organisational changes, which have resulted in the blending of competencies, perspectives, knowledge, skills and values, and identities that both enable and constrain professional work (Kerson, 2004; Frost et al, 2005; McGivern et al, 2015).
Enacting hybridity was a way of AMHPs articulating their professional role(s) and identities at the intersections of professional boundaries dialogically, with boundary spanning used to mobilise resources to get other professionals to acknowledge and take seriously a position that was being proposed. This included the negotiation and management of interprofessional conflicts, false starts and delays in the coordination of resources required for MHAA by AMHPs. Such negotiations occurred within a context where AMHPs recognised and overcame ironies in their practice encounters via the expression of ‘ironic dialogism’. ‘Ironic dialogism’ was a concept that highlighted how perceptions by AMHPs of being forced to adopt a direction of action against their will led them towards a propensity for resistance. This was signified by participants being sent on a ‘fool's errand’ (Willis, 2000), and when knowing this was a ‘fool’s errand’ they adapted their position through ‘ironic dialogism’; revealing the inherent contradictions between officially recognised and sanctioned practice and practice as it was encountered situationally and contextually. This concept was a key aspect for understanding AMHP professional practice. Hybridity in the AMHP role(s) and participants’ perspectives thus became a creative response to ‘ironies of adaptation’. ‘Ironic dialogism’ was the externalisation of those responses. Professional identities were hybridised as they involved enacting ‘ironies of adaptation’ in AMHPs’ everyday practices.

Types of hybridisation were extended through the HIP to include cross-cutting other professional roles in chapter 6 and through the enactment of hitherto invisible nested roles adopted contingently and discussed in chapter 7, to reveal the AMHP role as multifarious, working in liminal spaces in gaps left by other professionals. The liminality present in the spaces and places occupied by AMHPs where gaps are left enabled participants to enact and embody multiple professional roles, enacting differing identity positions depending on context and audience in response to addressivity. The occupation of liminal spaces, such as at
the magistrate’s court in Bernie’s example, offered insight into the ways AMHPs as boundary spanners adapted and adopted roles between different professional groups and within and across different organisations to negotiate positive care and treatment outcomes. AMHPs were found to reconcile divergent views and to provide a means of connection amongst diverse and dispersed professional groups, organisations and in public and private spaces. This required skilled mediation, negotiation and strategy to achieve desired care and treatment outcomes. Negotiation was the point between the two extremes of a dialogic exchange where the variety of possible responses could range from agreement to disagreement (Beech, 2008). Dialogue proceeded in ways that involved participants refining what was said and adapting to what was said by others to meet outcomes, to communicate a reason, usually legal or social, to recommend a change in the opinion of other professionals, as discussed in chapter 6. In these ways, the social and legal perspectives enacted and AMHP duties under the MHA 2007 were identity anchors (Department of Health, 2007). Responses were contingent as they moved between different organisational realms, but were used to participants’ advantage to align the divisions between the complex demands of MHAA with other professionals’ jurisdictions, with the enactment of boundary spanning being a mostly positive aspect of their professional role(s) as hybrid professionals. AMHPs were able to use their expertise via their perspectives in use to establish legitimacy and transform established professional practices, values and identities. The conceptualisation of AMHPs as hybrid professionals involved the ability and capacity to work with ambiguity and navigate the tensions between professional, organisational and administrative legal demands, and to engage in interprofessional discussions where tensions were most prevalent. Such discussion included different views on the characteristics of and priority of professional and organisational responses with a MHAA. The facilitative engagement of AMHPs in organisational and professional tensions was an important component of their institutional
work. Facilitative engagement involved (re) constructing the tensions experienced between AMHPs and other professionals, e.g. psychiatrists as productive rather than negative. At times, there was evidence of a disjuncture between the professional and organisational imperatives that focused on collaborative working arrangements; between what was expected through organisational and professional policies and the experienced realities of practice. This was managed through AMHPs’ enacting ‘ironic dialogism’.

Addressivity was a key aspect of professional practice and described how AMHP practice was enacted through the responses and responsibilities participants had towards significant others during MHAA. Addressivity showed how, through being addressed and addressing others, AMHPs authored their professional roles and identities, because the professional self was dialogic and existed as a relation to others through multivocality (Bakhtin, 1981; Yancey, 1994). The professional self was a dynamic multiplicity of positions enacted through dialogical relationships and roles, i.e. I as an ‘advocate’, I as a ‘legal advisor’ etc. This occurred within encounters based on participants’ espoused experiences of professional practice, between ‘real or imagined interlocutors’ (De Peuter, 1998), such as psychiatrists, whose professional practices were subject to unpredictability, and with service users.

Dialogic professional identities were related to hybridity through the interrelationships seen in figure 8.1 through the negotiation of hybrid positionings, via boundary spanning, ‘perspectives in use’ and hybrid roles. Dialogic professional identities were enacted through struggle and authorship of knowledge locations that were subject to revision, false starts, delays, improvisations and ironies. Within dialogical identities I have found that what was being exchanged fixed the meaning of professional identities as enactments of identity positions. In these ways, language scripted identities, and the language used via ‘perspectives
in use’ showed participants’ knowledge areas as hybridised because it spanned divergent areas of professional expertise. These findings suggest professional roles and identities are structured through dialogic exchanges, and suggest AMHPs can be conceptualised as hybrid professionals who practise hybrid professionalism through forms of dialogism due to the multifaceted, ambiguous and inferential nature of their professional work (Noordegraaf, 2007).

Considering research question 3, the HIP illuminated important implications for AMHP professional practice. AMHPs begin their professional practice with the advantage that theoretical perspectives that support hybridisation are partially integrated through the AMHP competencies and an educational framework that supports inter-professional practice (Mental Health Act, (A.M.H.P) Regulations, 2008). This educational focus was important in preparing AMHPs for a complex role enacted in the context of professional and organisational complexity and in situations where the prevalence of people experiencing interrelated mental health and physical health has increased (Marmott, 2010). I suggest the HIP could influence the current review of AMHP competencies to include the salient aspects of hybridisation within the revised competency framework by including competencies that support professional practice and development along the dimensionalities of hybrid ‘perspectives in use’, hybrid roles and boundary working. My interpretation of hybrid professionals and dialogical identities could be a valuable educational tool for AMHPs to make sense of their emerging professional role and identities during their education and training. As discussed above, AMHP education is hybridised, with units delivering lectures and group work from psychiatrists, lawyers and social work lecturers. The curriculum and teaching delivery is hybridised.
In terms of hybridity in education and training, Kate’s quotation below demonstrated how she drew on a holistic educational repertoire that cross-cuts traditional professional boundaries:

_We have practice improvement events at the trust, we have six weekly events where we arrange the speakers to commend and talk to us about various aspects, we have ‘Mental Health Act Cop’ (a police officer) recently ..., we’ve had psychologist coming in talking about specific things like Asperger's, we’ve had doctors come in and talk about, later life and nutrition and we’ve had social worker forums and will meet and discuss the new carer act, new legislation that’s coming... (Interview 2, 01.07.15)._ 

It is important that this educational focus is retained in the proposed new competency framework, as those who work as AMHPs in the HIP valued it and espoused that it was important for preparing AMHPs for real world practice. AMHPs have been selected by the new director of ADASS as a professional, organisational and national priority for workforce planning. Therefore, my research could inform this area of work and the findings may be interesting to the Department of Health and Chief Social Worker who are currently consulting on a new AMHP competency framework. My research contribution could be informative for social workers, nurses and occupational therapists planning to train as AMHPs. My research may be of interest to the field given that AMHP numbers are decreasing and few health AMHPs are training (Romeo, CSW Report, 2017).

**8.3 Further research**

The implications from my research suggest further research would be beneficial on the impact of hybridisation across multiple professional groups. Exploring other professional roles through the theoretical perspectives applied to my study could enable conceptualisations of hybridity and dialogic identities to be extended to generate new contributions to knowledge. Hybridity was both pluralistic and dialogical. It was pluralistic in the sense of
trying out different practice approaches, interventions, perspectives etc. and it was dialogical in that the outcome of such practices, e.g. detention under the MHA 2007, was achieved through and within dialogic exchanges AMHPs have with other significant professionals.

Ways of improving effective partnership working could be examined by designing a cross-professional study that focuses on how hybridity is achieved within and through joint working. A multi-professional study of those professionals working within MHA duties, such as psychiatrists, care coordinators, police and ambulance personnel, could illuminate what areas of hybridity are salient for each professional group involved in the same MHAA (Department of Health, 2007). Such a study could highlight difference and similarities between occupational cultures and the contested and competitive areas where professionals jostle for territory in the same areas of activity. Consideration could be given to how to improve professional relationships within this research so that the MHAA experience is less chaotic for professionals involved, and is more caring and responsive for people who require care, treatment and support under the MHA.

The nature of the hybrid roles found in the HIP did not investigate whether some roles were more desirable than others, and the nested roles discussed in chapter 7 may be viewed as more or less desirable by users of mental health services and government departments involved in law and policy making. Research into the value of enacted roles could be valuable, as the multifarious roles nested within the role of a legal applicant may cause confusion for those being assessed. An ethnomethodology of MHAAAs that explores role enactment around AMHPs’ decision to detain or not from people who have been assessed
under the MHA could reveal service users’ perceptions of AMHPs’ nested roles and their value.

Building on the HIP, further research could investigate the extent to which external sources influence identity enactments. Centrifugal and centripetal concepts are both internalising and externalising perspectives which the self transmits towards others, and it was these orientations revealed in my data that located my concept of ‘perspectives in use’ as an expression, externalisation and enactment of professional identities as hybridised. A participant observation study would illuminate this at the point of enactment and could extend knowledge of hybridity within AMHPs, and possibly in other mental health professionals, such as social workers.

The HIP has not investigated the status or privileging that takes place amongst and across professional groups. It has not explored positions of power, structure or agency. A further study that investigates how language is privileged within these concepts could build understandings of hybridity as they relate to power positions in terms of known conflicts between medical privileged ways of knowing and social perspectives. As AMHPs are largely situated in integrated health and social care organisations, an understanding of their role(s) and identities could take into greater account workplace cultures, professional status and cross professional learning, particularly, how healthcare cultures influence AMHP knowledge claims and professional role(s) and identities in multidisciplinary settings.
8.4 Contribution to knowledge

The HIP contributes to the fields of mental health, professional identities and hybridity in several ways. A novel interrelated conceptual framework of hybrid professionals and dialogic identities has been produced and is illustrated in Figure 8.1., where I suggest I have extended research on hybrid professionals through the HIP to include two new concepts: ‘perspectives in use’ and ‘ironic dialogism’. The conceptual framework has brought insights in the professional roles and identities of multi-professional AMHPs, meaning and explanations. These stories have not been heard before. This extends and offers a novel perspective for understanding AMHP multi-professional identities beyond current explanatory frameworks. The conceptual framework was important for showing how ideas of hybridity and dialogism were interconnected, and is a contribution to knowledge that could be extended to other fields focused on hybrid professionals and dialogic identities. In the field of mental health, conceptualisations of dialogic identities and hybrid professionalism have not been previously explored. Conceptualising AMHP professional identities as dialogic contributes to the field’s understanding of AMHP professional identities and literatures on concepts of dialogism and hybridity as a lens for understanding identities. I have produced an exemplary case study, reflecting real world practice on an area that has not been researched previously. The case study illuminates AMHPs’ biographies as they are enacted and located in the intersubjective professional realities of everyday life, contributing sociologically to broader understandings of professional hybridity and an understanding of boundary spanning as a site of (re)organisation for AMHP professional role(s) and identities. These findings could offer AMHPs a professional script from which to draw and could influence their professional role and possibly their professional identities, through reflecting what AMHPs are expected to do when they enter inter-professional practice. I believe my findings contribute to scholarship on
hybrid professionalism, by suggesting that AMHPs as hybrid professionals are influential in organisations characterised by complexity, where the character of their work as hybrid professionals was to construct problems and offer solutions through the enactment of hybrid practices, dialogic identities and ironic dialogism.

8.5 Limitations

It is important not to overstate the findings of the HIP, for caution should be exercised in assertions based on a relatively small database. Good case study is reflective and willing to consider alternative theoretical perspectives that can offer rival explanations. One of the advantages of the HIP is its uniqueness and capacity for understanding the case of the AMHP role and professional identities in a particular context at a particular time. In ‘The Paradox of Case Study’, Simons (1996) embraces the paradox between the study of singularity in case study terms and the search for generalisation. The HIP embraces paradoxes, the fluidity between enacting professional identities and roles and the shades and nuances contained within them. Understanding ironies and investigating the complex phenomenon of identities is an advantage of case study research, as researching complexities illuminates complex phenomenon and does not delimit or smooth over the paradoxes contained within them. It seeks to understand them and theorise why they may be occurring, thereby bringing meaning and understanding. I decided what questions to ask, how to ask them, what to observe and what to record and interpret. I drew out issues of interest from the data and constructed stories of my participants. I have decided how to (re)present participants’ stories through the dimensionalities of hybrid types. I have determined what data to include and focus on and what to exclude. In this way, as a case study researcher I was constantly making judgments about the significance of my data. For these reasons a key determinant of the quality of a piece of
case study research is the quality of the insights and thinking brought to bear by the researcher. Like all good researchers, I have tried to present adequate evidence, from the data, to support the interpretations I have made.

A disadvantage of case study research commonly cited is the difficulty of generalising from a single case (Yin, 2014). Additionally, the sorts of limitations that can be found in case study research include whether they present issues or findings that are unpopular, for example with policy makers or managers. Critics who do not like what case study researchers write can easily find reasons to dismiss those findings, by arguing the sample was too small or the researchers were biased (Yin, 2014).

By definition, case studies can make no claims to be generalisable, a term generally applied for statistically significant large scale surveys. Because the sample was small and idiosyncratic and because data was qualitative, there was no way to establish the probability that data was representative of some larger population of AMHPs. For some researchers this renders any case study findings as of little value. Yet, even though case studies cannot be representative of a larger population, they can provide more than an idiosyncratic understanding. Looked at differently, relatability offers an alternative and more meaningful view of the value of the case study approach I employed.

Inevitable tensions arise between the study of something unique and the need to generalise, as it is tempting to reveal both the unique, universal and the unity of that understanding. Relatability has the potential to yield both unique and universal understanding through judgement of the HIP’s value by AMHPs, AMHP educators and researchers. Existing theoretical perspectives can be contrasted against complex practice realities and the very
richness of the data can help generate new thinking and new ideas. Though thick description can be valuable in its own right, case study research really demonstrates its relevance when such new or modified thinking takes place. Where case studies generate new thinking, that thinking has a validity that does not entirely depend upon the cases from which it is drawn (Yin, 2014). Readers of case study research can judge whether or not the analysis presented sounds convincing, based upon what they know of similar situations and circumstances. This means that professionals could relate to my findings, because they recognise the sorts of situations that I have described. Conversely, my study may seem less relevant/attractive to policy makers, perhaps because I reveal some of the over-simplifications present in organisational discourses and the ironies upon which some policies and managerial practices are based.

The conceptual limitations of my study arise from the contested nature of the theoretical perspectives I drew on to explain the subject of professional roles and identities. AMHPs were grappling with contextual changes that impacted upon their role and identity constructions. As such, they were possibly unable to provide fully cogent articulations of their own professional identity constructions. As has been acknowledged by leading scholars in chapter 3, identities are complex, fluid and subjective. Limited evidence of AMHP self-perceptions of their own professional identity constructions were found and were arguably due to changes to the AMHP role and responsibilities and the impact of reduced resources under which participants were operating. These contextual factors have been found elsewhere to influence how identities are narrated. As individuals or contexts change, so too identities will alter within these interactions (Billot, 2010). For whilst identities are dynamic, the ‘self’ may need continuity to enable the presentation of a coherent self-perception of the professional self as it is reflexively understood to others, including researchers.
8.6 Final thoughts

Although professional roles and identities change over time due to the changing contexts in which practice is situated, studying professional roles and identities offers the field an understanding of the AMHP role and an interpretation of participants’ identities as dialogical. AMHPs were grappling with continual change that impacted upon their identity constructions. Their roles and responsibilities had become more demanding, and conflicts with other professionals occurred where priorities clashed.

The case of AMHPs as hybrid professionals negotiating dialogical identities was supported through empirical evidence. The participants had multiple and differing interpretations of who they were. How they contextualised their role and identities had an impact upon how they made sense of their workplace and their place within broader organisational spheres. I have made analytical generalisations based on the conceptual framework that was used as a lens for interpreting the research questions. However, these generalisations should be viewed in context and would require additional research to corroborate the phenomenon under examination. In conceptualising professional identities and role, I acknowledge their dynamic nature and the subjectivities of participants’ ‘imagined’ and ‘experienced’ perceptions (Billot, 2010).

It is important to organise professional work from within the research findings of professional practice. This is necessary for professional work to cope with new situations that arise in public services. The ability to engage in transformative practice at sites of hybridisation could create educational spaces to counteract dominant medicalised discourses, transform the status quo that privileges medicalised constructions over social constructions of mental health.
needs, and could ultimately make a difference to how AMHPs perceive and value their status. Knowledge of hybridised AMHP practice could facilitate a deeper understanding of how AMHPs exercise their agency to benefit vulnerable people with whom they work. If AMHPs embrace ambiguity then ironic practice and mediating relations through dialogism could be interpreted as new form of hybridity within professional identities.

In conclusion, participants narrated their work with individuals with complex health and social problems through their stories during interviews. These narrations revealed how participants crossed professional, disciplinary and organisational boundaries. Interpreting AMHPs as hybrid professionals incorporated a recognition of the complexity of their everyday practice as it was enacted dialogically with significant others in the workplace. Professional roles provided AMHP participants with meaning and purpose in their professional lives, and a sense of self that was interrelated with the identities they perceived themselves to inhabit. The participants had multiple different interpretations of their professional self, with their identities meaning different things to them. This was enacted in an ever-evolving journey of professional discovery, representing past occurrences that informed present and future discursive practices. My research aim was to encourage further discussion on the multi-professional role and identities of the AMHP within a specific context at a specific time, to illuminate the daily challenges AMHP dialogically navigated in contentious, complex circumstances. The challenge of my study has been to make visible the AMHP multi-professional role and participants’ identities to provide a contribution to the field. This was illustrated through the lens of AMHPs as hybrid professionals enacting dialogic identities.
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Appendix A - Stage One Topic Guide

Topic Guide

The main topics that I am interested in are:

- AMHP relationships with other professionals
- AMHP relationships with other AMHPs
- Conflicts and tensions in professional relationships
- I aim to explore these conversationally, but have questions that frame these areas if I need them.

Interview Guide

1.) Who are the main professionals that you work with?
2.) Tell me about your working relationships these professionals?
3.) Tell me about your working relationships with other AMHPs?
4.) Do you share a professional culture? Please give me examples.
5.) When you are undertaking mental health assessment work do you experience conflicts and or tensions with other professionals? Can you tell me about these and give me examples?
6.) Can you tell what you think is unique about the AMHP role? I am interested in hearing about the daily features of your AMHP practice, your experience of being an AMHP, the things you do, why you do them in the way you do and any perspectives that inform how you operate as an AMHP?
7.) Tell me about the knowledge, skills and values you bring to your role?
8.) What types of supervision do you receive? How often? Do you find it valuable?
9.) How else are you supported professionally?
10.) Tell me about your professional identity?
11.) What are the important characteristics and features in your view?
Appendix B - Stage Two - Career Story Interview

Please will you think about your career to date and think about your story of how you became an AMHP and what influenced you in this choice of career? You can either ‘tell’ me this story, or write it, whichever you prefer. If you prefer to talk, I will record what you say and you can of course have a copy of the transcript. I will destroy the recording once I have transcribed what you say. The transcript will be kept securely on a University password-protected computer. Put in whatever you feel is relevant. If you want to talk about cases or people remember confidentiality procedures and please be reassured that what you say will not be traceable to people you may wish to discuss. This is no right way, just do it in your own way and take as much time as you like.

Do you have any questions?

If it is okay, please may I turn the data recorder on now?
(The diagram is an example of what this may look like).

What influences my professional identity?

Here is a diagram that has been populated to illustrate influences on a participants’ identity. I would like to give you a white board to write on and note down what has influenced your professional identity? I would like you to place the most important influences in the middle of the diagram and then work out to periphery of influences that are still important but less so. Please feel free to remove your ideas and change them as you think through all the influences and take as long as you want, but it should be a task of minutes not hours. Also, if you would like to, you can draw on the board if you think there are links between influences using arrows etc - whatever feels best for you. I will then use this as a basis for us to talk about the influences on your professional identity.
Appendix D - Stage Three Interview

Please tell me how you think are similar and how you think you different to these professionals? It might help if you think about your professional knowledge and skills and the things that you do in your AMHP role or the way you act as an AMHP. You might also like to think about the way that others see your role too, but please say whatever you feel or think is relevant.

- Psychiatrists
- General Practitioners
- Lawyers
- Judges
- Police Officers
- Therapists

Can I ask you to please talk about the roles that you have as an AMHP? There is no right or wrong way to talk about your roles, just do it in your way and include whatever you feel is relevant. Take as much time as you like.
Appendix E

Title of Research

Shifting identities—How do Approved Mental Health Professionals develop their professional identities and what are the influences and professional features that shape this?

Participant Information Sheet

You are being invited to take part in a research study [as part of a student project – participants should be told about the overall aim of the research and whether it will be for a degree]. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Who will conduct the research? Caroline Leah, University Lecturer in the School of Brain, Behaviour and Mental Health, Ground Floor, Simon Building, Brunswick Street, Manchester. M13 9PL. Tele: 0161 275 5220.

Background

The role of the AMHP is a relatively recent professional role that has been extended from the previous Approved Social Work role to a range of other Mental Health Professionals, such as Mental Health Nurses, Occupational Therapist and Psychologists. As a new professional role tasked with assessing vulnerable people under the Mental Health Act 2007 and potentially depriving such people of their liberty via the detention process AMHPs face the challenge of achieving a coherent professional identity. This is particularly complex and problematic as AMHP straddle a number of professional boundaries that incorporate legal, social and leadership mandates.

Aim: The aim of the study is to explore how AMHPs perceive their professional identity.

Design and Methodology

The empirical work for this paper is informed by case study methodology, using the methods of semi-structured face to face interviews. This is informed by literatures on social identity (Goffman, 1959) and professional identity theories (Gee, 2012). Gee’s (2012) conceptual framework is being considered as a ‘thinking tool’ to analyse the data generated from a sample of ten Approved Mental Health Professionals.

What is already known about this topic?

Several scholars have commented upon the ASW and AMHP as complex role and of being dominated by higher status mental health professionals, mainly Psychiatrist and General Practitioners with whom AMHPs routinely work. This has lead commenters to speculate that AMHPs either have a medical identity as they are subsumed by the discourses of higher status professionals or have a weak sense of their professional identity.
What will this paper add?

It will extend the field of professional identities and explore how the Approved Mental Health Professionals perceive their professional identities, in terms of their everyday practice. It will contribute to knowledge production in the professional field of mental health practice.

Semi structured interviews

The main topics that I am interested in are:
- AMHP relationships with other professionals
- AMHP relationships with other AMHPs
- Conflicts and tensions in relationships
- I aim to explore these conversationally, but have questions that frame these areas if I need them.

Topic Guide

- Professional interactions between AMHPs and other mental health professionals for example psychiatrists, general practitioners, nurses, social workers, police officers, ambulance staff.
- Institutional rules, for example the organisational policies and legal frameworks that AMHP are required to work within and how these influence AMHP identities.

What is the aim of the research?

The research project aims to give an account of AMHP articulations of their professional identities, how social and medical models of disability inform ideas of professional identities in practice and why, how and when AMHPs give prominence to different articulations of identity constructs.

Who is being chosen?

A purposive sample of ten multi-professional AMHPs from Mental Health and Social Care Trusts in England will be chosen for the semi structured interviews. I will attend AMHP forums to elicit interest and take names of AMHPs who would like to participate and they will be recruited via Heads of Social Care.

What would I be asked to do if I took part?

I will invite you to take part in a semi structured face to face interview, where I will ask you questions about your daily practice, working with health professionals, working as part of a multi-disciplinary team and your values, knowledge and skills as an AMHP.

What happens to the data collected?

The data collected will be stored safely and in accordance with data protection law and confidentiality procedures and is for my sole use for the research study.

How is confidentiality maintained?
The data collected will be anonymised and coded so that it cannot be traced to any individual. It will be kept at the University of Manchester in a secure office in a locked filing cabinet. The audio taped transcriptions will be kept locked and secured on a password protected computer in a secure office. The audio recordings will be destroyed once the research has been completed.

**What happens if I do not want to take part or if I change my mind?**

It is entirely your choice to decide whether to take part. If you do decide to take part, I will give you this information sheet to keep and ask you to sign a consent form. If you decide to take part, you are still free to withdraw at any time without question or consequence.

**Will I be paid for participating in the research?**

Your participation is voluntary and unpaid.

**What is the duration of the research?**

Approximately one hour for the interview

**Where will the research be conducted?**

Ground Floor Offices, Simon Building, University of Manchester, Brunswick Street, Manchester. M13 9PL or workplace location as arranged.

**Will the outcomes of the research be published?**

It is anticipated that the research will be published in academic journals.

**Contact for further information** Please do not hesitate to contact me for further information

Email: caroline.leah@manchester.ac.uk

Tele no: 0161 275 5220 (Monday, Wednesday and Thursday)

If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Research Practice and Governance Co-coordinator by either writing to 'The Research Practice and Governance Co-coordinator, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research-Governance@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093
Appendix F

CONSENT FORM

Study Title
Shifting identities-How do Approved Mental Health Professionals develop their professional identities and what are the influences and professional features that shape this?

If you are willing to participate please complete and sign the consent form below

I confirm that I have read the attached information sheet on the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily. [ ]

I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason. [ ]

I understand that the interviews will be audio recorded [ ]

I agree to the use of anonymous quotes [ ]

I agree that any data collected may be published in anonymous form in academic books or journals. [ ]

I agree to take part in the above project

Name of participant ___________________________ Date ______________ Signature ___________________________

Name of person taking consent ___________________________ Date ______________ Signature ___________________________
## Appendix G - Interview dates and locations

<table>
<thead>
<tr>
<th>Participant</th>
<th>Interview dates</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
<td>Stage 2: 22/06/15</td>
<td>Workplace</td>
</tr>
<tr>
<td></td>
<td>Stage 3: 17/11/15</td>
<td>Workplace</td>
</tr>
<tr>
<td>Matthew</td>
<td>Stage 1: 13/01/15</td>
<td>Workplace</td>
</tr>
<tr>
<td></td>
<td>Stage 2: 22/06/15</td>
<td>Workplace</td>
</tr>
<tr>
<td></td>
<td>Stage 3: 03/11/15</td>
<td>Workplace</td>
</tr>
<tr>
<td>Dawn</td>
<td>Stage 1: 17/11/14</td>
<td>Workplace</td>
</tr>
<tr>
<td></td>
<td>Stage 2: 19/05/15</td>
<td>Workplace</td>
</tr>
<tr>
<td></td>
<td>Stage 3: 17/11/15</td>
<td>Workplace</td>
</tr>
<tr>
<td>Elizabeth</td>
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</tr>
<tr>
<td></td>
<td>Stage 2: 21/04/15</td>
<td>Her home</td>
</tr>
<tr>
<td></td>
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<td>Her home</td>
</tr>
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<tr>
<td></td>
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<td>Stage 3: 13/11/15</td>
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<td>William</td>
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<td></td>
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<td>Diana</td>
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<td>University</td>
</tr>
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</table>
### Appendix H - Extract of Influences on Career

**Influences on Career – What influenced you to become an AMHP?**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Inner circle influences</th>
<th>Outer circle influences</th>
<th>Notes Common themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon (Nurse)</td>
<td>New AMHP role; New Challenges; Unique role for service user support; Professional development; Critical Understanding.</td>
<td>LSSA support; Role Models; Being a Deputy manager; MHA amendments; Support multidisciplinary team; Increased awareness; Used as a source</td>
<td>Role models; Professional development</td>
</tr>
<tr>
<td>Matthew (Nurse)</td>
<td>Talking with nurses, support workers; Attitudes/values of colleagues; To develop better knowledge of other roles/ link; Service user understanding/concerns; Impact of care and treatment; Individual colleagues/peers; To deliver/influence care in a way that service users want/value that’s dignified, respected; To develop own skills/knowledge; Dealing with people in different roles to yours.</td>
<td>Research around best practice and ways to implement legal aspects of care framework; politics local and national; services for local needs/cultural; Become a role model for others; To promote awareness of understanding of mental illness.</td>
<td>Role models; Professional development; Status</td>
</tr>
<tr>
<td>Dawn (OT)</td>
<td>My PDP training, literature; Media and education; Experience of working in homeless and vulnerable groups; OT extended roles and KSF.</td>
<td>Supervision; Students; My values and experiences.</td>
<td>Role models; Professional development; Values</td>
</tr>
<tr>
<td>Elizabeth (SW)</td>
<td>Life Experience, Ethics, Stigma.</td>
<td>Politics and education; Women; Monetary gain; Status;</td>
<td>Role models; Values (ethics); Status</td>
</tr>
<tr>
<td>Annette (SW)</td>
<td>Life experience; Career; Education; Fairness; Justice: Power: Knowledge: Financial; Achievement – better me.</td>
<td>Voice; Can do better; Fortunate; Politics: Law; Humanity: Information Thirst: Career Development: Application of piece of puzzle: Service and</td>
<td>Role models, Values</td>
</tr>
<tr>
<td>Name</td>
<td>Responsibilities</td>
<td>Role Models</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>William (SW)</td>
<td>Really enjoyed opportunities; LCC funded opportunity to do an MA; Wanting to build on support worker role, develop skills; second job – support worker with adults with MH problems; First job after university - older people with dementia in a day centre.</td>
<td>Role models; Professional development; Status.</td>
<td></td>
</tr>
<tr>
<td>Tina (SW)</td>
<td>Service users, people (Dad, Mum, Friends), Godmother, service users, enjoyment of working with people.</td>
<td>Role models.</td>
<td></td>
</tr>
<tr>
<td>Diana (SW)</td>
<td>Reading, Service users, Voluntary work; Family; Education.</td>
<td>Role models; Values.</td>
<td></td>
</tr>
<tr>
<td>Bernie (SW)</td>
<td>Experiences, wanting to help others, Family, Good managers, wanting to do the right thing, the law, carer experience, service user experience</td>
<td>Role models; Professional Development; Values</td>
<td></td>
</tr>
</tbody>
</table>
| Kate (SW)    | Having AMHP students and NQSW’s, training and conferences, political leaders, national policies about mental health, being with other social workers in a team, Experience, HCPC (regulation and codes of conduct), other non AMHP colleagues, reading, research on mental health social work. | Role models.                                                                 

- MH suited me; A very good manager in 2nd job; Having confidence to pursue a career – encouragement from friends and colleagues; Feeling that care coordinator could do more for a person and so meant to be a SW to do this; Compulsory AMHP training; To have a career to pursue, better life for self.

Role models:

- Class; research; colleagues
- Values; Politics; Colleagues; Career development
- Media, ongoing professional development, politics and policy, inspirational people, education.

Family life experiences and upbringing; My (AMHP) practice Assessor, Social work and AMHP training, Having a professional lead for social work in the Trust, The law, Colleagues other AMHPs and social workers, social model

Role models.
### Appendix I - Conceptual Framework - First Iteration for Stage One Interviews

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Key authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working <strong>relationships</strong> with AMHP and other colleagues – examples of...look for in-group and out-group dynamics.</td>
<td>Goffman, 1959; Jenkins, 2002.</td>
</tr>
<tr>
<td>MEDICAL PERSPECTIVES</td>
<td></td>
</tr>
<tr>
<td>PSYCHOLOGICAL PERSPECTIVES</td>
<td></td>
</tr>
<tr>
<td>BIO PSYCHOSOCIAL PERSPECTIVES</td>
<td></td>
</tr>
<tr>
<td><strong>Conflicts and tensions</strong> examples of</td>
<td>Goffman, 1959; Jenkins, 2002.</td>
</tr>
<tr>
<td><strong>In and outgroup dynamics</strong></td>
<td>Goffman, 1959; Jenkins, 2002.</td>
</tr>
<tr>
<td>Sameness and difference</td>
<td></td>
</tr>
<tr>
<td>Examples of collaboration with other profs, part of <strong>professional culture, Communities of practice?</strong></td>
<td>Quirk <em>et al.</em>, 2000; Wenger, 2003.</td>
</tr>
<tr>
<td>Supervision – how does this speak to professional culture, identities?</td>
<td>Schon, nda.</td>
</tr>
<tr>
<td><strong>Skills</strong> (communication, listening, coordinating, conveyance, leadership, negotiating, mediating, advocating)</td>
<td>Quirk <em>et al.</em>, 2000;</td>
</tr>
</tbody>
</table>
**Appendix J - Conceptual Framework - Second Iteration for Stage Two Interviews**

The key ideas and concepts used as an educational lens for thinking, theorizing, analysing interpreting and discussing data.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Key authors</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Dialogical identities</em></td>
<td></td>
</tr>
<tr>
<td>- self-authorship (self as multiple, agentic)</td>
<td></td>
</tr>
<tr>
<td><em>Sameness and difference</em></td>
<td></td>
</tr>
<tr>
<td><em>In and outgroups</em></td>
<td></td>
</tr>
<tr>
<td><em>Transgression</em> or outsiders*</td>
<td></td>
</tr>
<tr>
<td>Construction of identities identification</td>
<td></td>
</tr>
<tr>
<td><em>Language</em> as a resource for theorizing</td>
<td></td>
</tr>
<tr>
<td>Embedded in language (how are stories described and orientated, used to make sense of professional identifications and identities) What language is used, what language is shared or distinct?</td>
<td></td>
</tr>
</tbody>
</table>

|-------------------------------|                                                                            |
| As a site of a *dialogical definition of the self* |                                                                            |
| Situated *dialogical narratives* |                                                                            |
| *Borders* of identity sameness and differences |                                                                            |

| **HYBRIDITY**                 | Brown *et al*; Quirk *et al*; Danielewicz, 2001; Tew, 2001; Pilgrim, 2002; Fakhoury and Wright, 2004; Rapaport, 2006; Nathan and Webber, 2010; Gregor, 2010; Morriss, 2015a, 2016; Rapaport, 2006; Nathan and Webber, 2010. |
|-------------------------------|                                                                            |
| As *discursive and dialogical* |                                                                            |
| Visible in:                   |                                                                            |
| *Perspectives/ideologies* – BPS, social, psychological, legal, medical, therapeutic, service user. |                                                                            |
| SOCIAL PERSPECTIVES           |                                                                            |
| MEDICAL PERSPECTIVES          |                                                                            |
| PSYCHOLOGICAL PERSPECTIVES    |                                                                            |
| BIO PSYCHOSOCIAL PERSPECTIVES | Benefits of examples                                                         |
| Hybrid expertise – intersections, divergences. |                                                                            |

| Legal, psychiatric/medical/ social | Advocate, detective, administrator, conductor, judge, quasi-judicial, ‘jack of all trades, master of none.’ |
| Zones of inter-professional conflict, tension and collaboration Gaps, third spaces, interstatilities, liminalities Fixed boundaries of regulated AMHP role (distinctive knowledge, skills and value claims in stories), fluid boundaries (other). Navigating borders that separate professional identities. | |
| Professional culture/ context of practice in teams/ organisation | Oliver, 2013; Mc Givern et al, 2015; Spyridonidis et al, 2015; Solomon, 2016. |
| DIALOGICALISM Heteroglossia- Language as ideological saturated, a way of conceiving the world constituted by multiplicity of languages each with its own formal markers. Perspectives in use drawn from myriad available responses as signifiers of professional identities. All words have the taste of a profession...'(Bakhtin, 181, p.280) Contains ideas of struggle, resistance in talk. Addressivity to be addressed and to answer in social relations. Meaning is negotiated. Use of improvisation to navigate contradictions between the ‘rule book’ and the real world as contingent, negotiated. Subjectivities – what public discourses (e.g. NPM) are inscribed in AMHP intersubjectivities. Dialogical exchanges - In seeking to be heard and to influence. Benefitting their desired objectives (linked to values that influence perspectives- in -use) | Walter, 2003; Holland and Lave, 2000; Gunter and Bradbury, 2006. |
| 3.) HYBRID Values | Tew 2001; Pilgrim, 2002. |
|---|---|---|
| 8. | DIALOGISM | Holland and Lave, 2000; Gunter and Bradbury, 2006. |
## Appendix K - Final conceptual framework applied across whole of the data set after Stage Three Interviews for data coding

Colour coded for data analysis.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Key authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>As discursive and dialogical. Perspectives in use – social, psychological, medical, service user, biopsychosocial. Visible in: Language used, knowledge, skills, values claims. Perspectives in use /ideologies – BPS, social, psychological, legal, medical, therapeutic, service user. SOCIAL PERSPECTIVES MEDICAL PERSPECTIVES PSYCHOLOGICAL PERSPECTIVES BIO PSYCHOSOCIAL PERSPECTIVES</td>
<td>Brown et al, 2000; Quirk et al 2000; Danielewicz, 2001; Tew, 2001; Pilgrim, 2002; Fakhoury and Wright, 2004; Rapaport, 2006; Nathan and Webber, 2010; Gregor, 2010; Morriss, 2015, 2016; Rapaport, 2006; Nathan and Webber, 2010.</td>
</tr>
<tr>
<td>HYBRID Skills Skills – are they defined by professional competencies, or broader, skills of dialogue, persuasion – invisible?</td>
<td>Tew 2001; Pilgrim, 2002; AMHP Regulations, 2008; MHA Code of Practice, 2008;</td>
</tr>
</tbody>
</table>

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user needs and enhancing the quality of provision

| Hybrid identities – is there a type? From pure to extended professionals? |
|-----------------|--------------------|
| ‘Hybridity of the everyday’ | Willing/incidental hybrids |
| Uni hybrid or multiple hybrid identities |

| Hybrid Roles – what roles are claimed by AMHPs? |
|-----------------|--------------------|
| Legal, psychiatric/medical/social Advocate, detective, administrator, conductor, judge, quasi-judicial, ‘jack of all trades, master of none.’ |

| Weinrach et al., 2001; Denis et al., 2005; Tate, 2007; Noordegraaf, 2007, 2015. |

<table>
<thead>
<tr>
<th>BOUNDARY SPANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdictions of AMHP practice</td>
</tr>
<tr>
<td>Zones of inter-professional conflict, tension and collaboration</td>
</tr>
<tr>
<td>Gaps, third spaces, interstatilities, liminalities</td>
</tr>
<tr>
<td>Fixed boundaries of regulated AMHP role (distinctive knowledge, skills and value claims in stories), fluid boundaries (other).</td>
</tr>
<tr>
<td>Navigating borders that separate professional identities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOUNDARIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a site of a dialogical definition of the professional self</td>
</tr>
<tr>
<td>Situated dialogical narratives</td>
</tr>
<tr>
<td>Borders of identity sameness and differences</td>
</tr>
<tr>
<td>Boundary crossing/jurisdictions of AMHP practice – zones of inter-professional conflict, tension and collaboration.</td>
</tr>
<tr>
<td>Professional culture/context of practice in teams/organisations</td>
</tr>
</tbody>
</table>

| Aldrich and Herker, 1977; Bar-on, 1994; Nissan, 2010; Knott and Bannigan, 2013; Oliver, 2013; Mc Givern et al., 2015; Spyridonidis et al., 2015; Solomon, 2016; Walter, 2010; Oliver, 2013; Morriss, 2015; Webb, 2017. |

<table>
<thead>
<tr>
<th>DIALOGISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heteroglossia- Language as ideological saturated, a way of conceiving the world constituted by multiplicity of languages each with its own formal markers.</td>
</tr>
<tr>
<td>Perspectives in use drawn from myriad available responses as signifiers of professional identities. All words have the taste of a profession...’ (Bakhtin, 181, p.280) Contains ideas of struggle, resistance in talk.</td>
</tr>
<tr>
<td>Addressivity to be addressed and to answer in social relations. Meaning is negotiated.</td>
</tr>
</tbody>
</table>

| Use of *improvisation* to navigate contradictions between the ‘rule book’ and the real world as contingent, negotiated.  
Diallogical exchanges - In seeking to be heard and to influence. Benefitting their desired objectives (linked to values that influence perspectives in use)  
DIALOGISM – pluralistic views, judgments on how to converse depending on who talking with, determines choice of language.  
DIALOGICAL IDENTITIES  
*Dialogical identities* - self-authorship (self as multiple, agentic)  
*Sameness and difference*  
*In and outgroups*  
*Transgredience* or outsideness  
*Construction of identities* identification of  
*Language* as a resource for theorizing  
Embedded in language (how are stories described and orientated, used to make sense of professional identifications and identities)  
What language is used, what language is shared or distinct?  
Holland and Lave, 2000; Willis, 2000; Quirk *et al*, 2000. |
Appendix L - Emerging Data Themes from Stage One

Development of Thematic Structure

First Themes – one iteration from all participants
Second order themes – two or more iterations from all participants

1. PROFESSIONAL IDENTITIES
   A local theoretical perspective of hybrid(ised) professional identit(ies)

2. HYBRIDITY
   Boundary crossing
   Hybrid roles-conflicts, tensions, ironies
   Hybrid perspectives/ideologies – ‘perspectives in use’
   Hybrid identities-conflict, tensions ironies, relationship with context/ organisational structures/other professionals
   Use of improvisation
   Dialogism in identity enactment
   Pragmatism as an ironic response to contradictions in enacting AMHP practice
   Incompatibilities to role definition, being more than a legal AMHP
   Status
   Conflicts and Tensions-with police and ambulance crew, services such as Crisis Response and Home Treatment and differences of perspective about the nature and causation of mental disorder with Psychiatrists (Medical v Social Models v BPS model).
   Hybrid knowledge-Knowledge of psychiatry, law, social perspectives, mental disorder/illness/distress, of alternative resources that can be used instead of hospital admission
   Hybrid Language-what language is in use?
   What is distinctive about being a hybrid professional for AMHPs?

5 VALUES
   Values of social justice, human rights perspectives fairness, advocacy, anti-discriminatory practice and best interests (Mental Capacity Act, 2005)

6 SKILLS
   Skills – communication (listening, rephrasing, reframing,) risk management, leadership, coordinating/collaborating in the Mental Health Act process. (Conveyance, arrangements for children, pets, etc. how this is negotiated and relational)

7 AFFINITY IDENTITIES
   Affinity – shared practices, language, peer support, local and regional forums to share problems, issues, this seems to be active rather than passive, seems that it's used to solve AMHP professional problems. Gee (2001). Common endeavours and practices are very prominent across all participants

8 SIGNATURE PEDAGOGIES
   Perspectives, ideologies in education and training
   Role Models - an emergent theme, seen as a major influence on who AMHPs are and how their professional practice and identity is shaped. Particularly apparent with how practice assessor (mentors for trainee AMHPs) influence and shape AMHP identity.
   Also, other role models, university tutors, peers, managers and family members
Appendix M - Emerging Data Themes from Stage Two

Development of Thematic Structure

First Themes – one iteration from all participants
Second order themes – two or more iterations from all participants

PROFESSIONAL IDENTITIES

A local theoretical perspective of hybrid professional identit(ies)

1. HYBRIDITY
Boundary crossing
Hybrid roles – conflicts, tensions, ironies
Hybrid perspectives/ideologies – perspectives in use
Hybrid identities – conflict, tensions ironies, relationship with context/ organisational structures/other professionals.
Use of improvisation
Dialogism in identity enactment
Pragmatism as an ironic response to contradictions in enacting AMHP practice
Incompatibilities to role definition
Status
Conflicts and Tensions - with police and ambulance crew, services such as crisis response and home treatment and differences of perspective about the nature and causation of mental disorder with psychiatrists (medical v social model).
Hybrid knowledge - knowledge of psychiatry, law, social perspectives, mental disorder, of alternative resources that can be used instead of hospital admission.
Hybrid language – what language is in use? Illuminated in perspectives in use
What is distinctive about being a hybrid professional for AMHPs?

KNOWLEDGE
VALUES
SKILLS

2.) KNOWLEDGE

Values of social justice, human rights perspectives fairness, advocacy, anti-discriminatory practice and best interests (Mental Capacity Act, 2005)

3.) VALUES

4.) SKILLS

Skills – communication (listening, rephrasing, reframing,) risk management, leadership, coordinating/collaborating in the Mental Health Act process (Conveyance, arrangements for children, pets, etc. how this is negotiated and relational)

6.) SIGNATURE PEDAGOgies
Perspectives, ideologies in education and training
Role Models - an emergent theme, seen as a ? major influence on who AMHPs are and how their professional practice and identity is shaped. Particularly apparent with how practice assessor (mentors for trainee AMHPs) influence and shape AMHP identity. Also, other role models, University tutors, and family members.

7.) IRONIES

8.) ROLE MODELS

9.) IDENTITY INFLUENCES
Improving practice and professional development, career progression, better outcomes for service users and families, helping others, increased status perceived from doctors, other colleagues.

10.) IDENTITIES.

11.) Dirty work and ‘Atrocity’ stories – as a shared resource for identity enactment, inter-related to ironies
Appendix N - Emerging Data Themes from Stage Three

1. HYBRIDITY

Boundary crossing
Hybrid roles – conflicts, tensions, ironies
Hybrid perspectives/ideologies – perspectives in use
Hybrid identities – conflict, tensions ironies, relationship with context/organisational structures/other professionals
Use of improvisation
Dialogism in identity enactment
Pragmatism as an ironic response to contradictions in enacting AMHP practice
Incompatibilities to role definition
Status
Conflicts and Tensions - with police and ambulance crew, services such as crisis response and home treatment and differences of perspective about the nature and causation of mental disorder with psychiatrists (medical v social model)
Hybrid knowledge - knowledge of psychiatry, law, social perspectives, mental disorder, of alternative resources that can be used instead of hospital admission
Hybrid Language – what language is in use? Illuminated in perspectives in use

• What is distinctive about being a hybrid professional for AMHPs? As discursive and dialogical
• Perspectives in use – social, psychological, psychiatric, service user, biopsychosocial.
• Visible in: Language used, heteroglossia, knowledge, skills, values claims
• Perspectives in use /ideologies – BPS, social, psychological, legal, medical, therapeutic, service user
• SOCIAL PERSPECTIVES
• MEDICAL PERSPECTIVES
• PSYCHOLOGICAL PERSPECTIVES
• BIO PSYCHOSOCIAL PERSPECTIVES
• Benefits of examples
Hybrid expertise – intersections, divergences.

2.) HYBRID KNOWLEDGE Perspectives in use – social, therapeutic/psychological, psychiatric, service user, biopsychosocial.

3.) VALUES
Values of social justice, human rights perspectives, fairness, advocacy, anti-discriminatory practice and best interests (Mental Capacity Act, 2005)

4.) SKILLS
Skills – communication (listening, rephrasing, reframing,) risk management, leadership, coordinating/collaborating, smoothing in the Mental Health Act process. Conveyance, arrangements for children, pets, etc. how this is negotiated and relational

5.) DIALOGICALISM

• Heteroglossia - language as ideologically saturated, a way of conceiving the world constituted by multiplicity of languages each with its own formal professional markers. Perspectives in use drawn from myriad available responses as signifiers of professional identities. All words have the taste of a profession…” (Bakhtin, 181, p.280) Contains ideas of struggle, resistance in talk
• Addressivity to be addressed and to answer in social relations. Meaning is negotiated.
• Use of *improvisation* to navigate contradictions between the ‘rule book’ and the real world as contingent, negotiated

• *Dialogical exchanges* - in seeking to be heard and to influence. Benefitting their desired objectives. Linked to values that influence *perspectives in use*

• DIALOGISM – pluralistic views, judgments on how to converse depending on who talking with, determines choice of language. Ironic dialogism/banter. Irony of representation

• Use of *improvisation* to navigate contradictions between the ‘rule book’ and the real world as contingent, negotiated

6.) BOUNDARY SPANNING

• Jurisdictions of AMHP practice

• Zones of inter-professional conflict, tension and collaboration

• Gaps, third spaces, interstatilities, liminalities

• Fixed boundaries of regulated AMHP role

• Distinctive knowledge, skills and value claims in stories

• Fluid boundaries (other)

• Navigating borders that separate professional identities.

**BOUNDARIES**

As a site of a *dialogical definition of the professional self*

• Situated *dialogical narratives*

• **Borders of identity sameness and differences**

• Boundary crossing/ jurisdictions of AMHP practice – zones of inter-professional conflict, tension and collaboration

• Professional culture/ context of professionalism, professionality

• Other territories
Appendix 0 - Exemplar narratives of hybridity

- Hybrid roles
- Perspectives in use/heteroglossia
- Dialogism as an expression of hybridisation through centripetal, centrifugal, transgression, addressivity concepts.
- Benefits of hybridity willingness, incidental – not investigated.
- Disadvantages of hybridity
- Influencing hybrids
- Protecting boundaries
- Navigating boundaries dialogically (on the margins, liminality)
- Crossing boundaries jurisdictions dialogically
- Hybridity and its relationship to professionality
- Disrupting professional boundaries to improve care
- Challenging poor professional practice
Appendix P - Transcription exemplar

Elizabeth - Stage 1 Interview

C: So moving on now to thinking about section 12 doctors, can you tell me how you work with them?

E: Section 12 doctors, they’re very difficult to get hold of, extremely difficult to get hold of. We have a long list of section 12 approved doctors and probably people on that list that are readily available, so we tend to use the same section 12 doctors. I had one the other day and I tried 11 section 12 doctors and it was a Friday afternoon and a woman and she’s just been put on a 5:2 (holding section) and I couldn’t get anyone to go out. So, I then had to wait until Monday to go out to do the assessment when I sorted out section 12 Dr’s and the implications for that lady... you can’t treat on a 5:2 and she had prepuceal psychosis, she was on the ward, but obviously can’t treat on a 5:2 and that was the dilemma. So, I then had to arrange, as I say for a section 12 Dr, because my 72 hours was up on the Monday and if I could have got one earlier we could have treated her on the Friday. That was a huge dilemma for me because I was thinking should I go on a Saturday, see if I can get a doctor on the Saturday, but then we don’t work on a Saturday and I don’t know, I think (even you wouldn’t be covered, going as an AMHP on a Saturday) Two F1’s are always very good at coming out on the assessment, one of the section 12’s is an older person psychiatrist so he’s very good, very skilled and very knowledgeable and the other section 12 is a GP is also very, very good and I trust them, because I have been out the section 12 haven’t got else, and will take the lead from you and don’t say anything, and will probably sign anything or will say I have a look at the recommendation, and I think well this is your professional judgement, this is not about what another professionals written and I don’t have confidence in them.

We have a good working relationship with the section 12 so no, they know us, how we work and that’s important as well for the service user and as I say and I keep saying, I feel confident that they know who they’re doing and I feel confident the professionals, their filling in a recommendation, that they’ve done a full and well-rounded assessment, that they’ve copied off anyone else’s recommendation.

C: Tell me now about the issues when you’re working with the police?

E: I think two words really, absolute nightmare, it’s an absolute nightmare trying to get the police out, what will usually say is, there’s somebody gone missing in... there’s been a serious incident, we will be there but we don’t know when will be there, and it will take hours, I think on one assessment I waited six hours for the police. It wasn’t in somebody’s home, it was in a communal area in the garden, because it was somebody’s flat and it was the hottest day of the year, this year, and I had to stay in the garden with him because if he went inside, I’d have to go and get a warrant, so I had to stay in the garden with him and the police, I wanted the police to convey him, this young man in the police car because he was very aggressive and the police said: ‘No were not going to because he’s actually settled down and, well wait for the ambulance’, so in that case, it was the ambulance that took six hours, but the police could have conveyed him. It would have been in his best interest because he met the criteria, he was very, very aggressive, so it was horrible. I had to stay like I say in a small garden area on the hottest day of the year and the police stayed with me, but it wasn’t in the service user’s best interest but the ambulance was taking forever to turn up...

And in that instance, they said: ‘we will take in the van in the caged area but you need to find something for him to say that is mental health is fit for that’, and I said: ‘no I’m not signing anything because I don’t know what’s going to happen when you put him in that environment’, when he was really aggressive I wouldn’t have signed anything more because it would have been in his best interests. And as like ‘We’re giving you this responsibility, and
If anything happens to the service user... and I'm giving you the signature of this AMHP which was an awful situation to be in, but generally the police will turn up hours later.

C - And when you get there, does the police understand what the role of the AMHP is?
E - No. They certainly don't understand the role of the AMHP and take directions from us to be quite honest, and nurses are also important in some ways I'm being unfair. It's a mixed bag, some police officers are very good, the other police officers are not really interested in you, find that in all walks of life and they are under enormous pressure as well, so I do feel for them.

The last assessment I did they were superb, because the psychiatrist and the section 12 went into the property with me, and then I was waiting for the police, and the police didn't turn up for two hours, so I then retreated and sat, waited in the car and in the police officers came and I requested the ambulance and they sat there while we waited the ambulance so they were very, very, good and because I'd already come out of the house if the woman hadn't of let me in and I would have had to have gone for a warrant so they were very supportive they were very nice with the service user and she let us back into the property freely and it went smoothly. But, it could have been an awful lot different. So, I can't speak highly enough of them there. It's the same in every profession you're going to get people who work with you.

C - And how to find the ambulance crew?
E - Mostly okay, it's a mixed be they understand our role more so than the police, generally more so than the police. I think because I have longer to talk to them to be quite honest and they ask more questions about what's going on, what section is the person on, the police is more at let's manage the risks.

C - So thinking about how referrals come to you?
E - It can be by the psychiatrist, can be by another professional, it'll be by the psychiatrist at the team, adding the referrals from other professionals are pretty good, because if it's been a care coordinator from our team, then we had a chance to have a dialogue about what's happening, and it's not usually something that happens overnight it's due to a build-up and then just as a care coordinator or a fellow professional, we can advise people to say, look at least restrictive before we go down that route, so it's probably a more fluid way of actually coming to the decision that we need to go down Mental Health Act assessment with psychiatrist. Again, within that team it's a chance that dialogue with other professionals is very much a done deal or so they think because the recommendations done, but as I say less so within our team.

C - So moving on now to knowledge, skills and values could you tell me what you think are the main pieces of knowledge that you think you need to be a good AMHP? E - Obviously, the Mental Health Act, the Mental Capacity Act, the interface with the Mental Health Act, Mental Capacity Act, knowledge of service provisions, I don't know what else in terms of knowledge?

Has it flummoxed you this question?

E - Yes, I've gone blank... Mental disorder and how they manifest especially when you're talking about nature and degree, and when it's appropriate to use the Act and how the Act will play out particularly with nature yes it's a good overview of mental disorders but that's also where we can pick the brains of the psychiatrist as well, because at the end of the day, were not medical but we do have to have a good overview of, but also medication, obviously not to the same level as the CPN as a doctor but certainly a good overview of what medication we use, and the side-effects and even dosage so if someone.

Horne Stage 3 C - So moving on now to thinking about section 12 doctors, can you tell me how you work with them?

E - Section 12 doctors, they're very difficult to get hold of, extremely difficult to get hold of.
We have a long list of section 12 approved doctors and it’s probably people on that list that are readily available, so we tend to use the same section 12 doctors. I had one of the other day and I tried 13 section 12 doctors and it was a Friday afternoon and a woman was just been put on 5.22 (ticking section) on the other side of X and I couldn’t get anyone to go out. So, I then had to wait until Monday to go out to do the assessment when I sorted out section 12 Dr. and then the implications for that lady... you can’t treat on a 5.22 and she had peripneumonic, she was on the ward, and obviously can’t treat on a 5.22 and that was the dilemma. So, I then had to arrange, as I say for a section 12 Dr. because my 72 hours was up the Monday and if I could have got one earlier we could have treated her on the Friday. That was a huge dilemma for me because I was thinking should I go on a Saturday, see if I can get a doctor on the Saturday, then we don’t work on a Saturday and I don’t know, I think legally you wouldn’t be covered, going as an AMHP on a Saturday, Two, 12s are always very good at coming out on the assessment, one of the section 12s was an older person psychotically so he’s very good, very skilled and very knowledgeable and the other section 12 is an GP as well, very very good and I trust them. Because, I’ve been out the section 12 haven’t got much, and will take the lead from you and don’t say anything, and will probably sign anything or will say can I have a look at the recommendation, and I think well this is your professional judgement, this is not about what another professional written and I don’t have confidence in them.

We have a good working relationship with the section 12 so on, they know us, how we work and... that’s important as well for the service user and as I say and I keep saying, I feel confident that they know what they’re doing and I feel confident the professionals, their filling in a recommendation, that they’ve done a full and rounded assessment, that’s all copied off anyone else’s recommendation.

C - Tell me now about the issues when you’re working with the police?

E - I think two words really, absolute nightmare, it’s an absolute nightmare, trying to get the police out, what they will usually say is, there’s somebody gone missing in... there’s been a serious incident, we will be there but we don’t know which will be there, and it will take hours for the police. I wasn’t in somebody’s 6 hour day for the police. I wasn’t in somebody’s 6 hours a day in the garden, because it was somebody flat and it was the hottest day of the year this year, and I had to stay in the garden with him because if he went inside. I’d have to go and get a warrant, so I had to stay in the garden with him and the police, I wanted the police to convey him, this young man in the police car because it was very aggressive and the police said, ‘No we’re not going to because he’s actually settled down, and well wait for the ambulance’, so in that case, it was the ambulance that took six hours, but the police could have conveyed him, it would have been in his best interest because he met the criteria, he was very, very aggressive, it was terrible, I had to stay like I say in a small garden area on the hottest day of the year and the police stayed with me, but it wasn't in the service user’s best interests but the ambulance was taking forever to turn up. And in that instance, they said, ‘we will take in the van in the garden area but you need to find something for him to sit that is mental health is fit for that’, and I said, ‘no I’m not signing anything because I don’t know what’s going to happen when you put him in that environment’, when he was really aggressive I wouldn’t have signed anything more because it would have been in his best interests. And as like ‘We’re giving you this responsibility, and if anything happens to the service user...’ and I’m giving you the signature of this AMHP which was an awful situation to be in, but generally the police will turn up hours later.

C - And when you get there to the police understand what the role of the AMHP is?

E - No. They certainly don’t understand the role of the AMHP and take directions from us to be quite honest, and nurses are all about risk management and suppose in some ways I’m being unfair. It’s a mixed bag, some police officers are very good, the other police officers are not really interested in you, find that in all walks of life and they are under enormous
pressure as well, so I do feel for them.

The last assessment I did they were superb, because the psychiatrist and the section 12 went into the property with me, and then I was waiting for the police, and the police didn't turn up for two hours, so I then recanted and sat, waited in the car and in the police officers came and I requested the ambulance and they sat there while we waited the ambulance so they were very, very, good and because I'd already come out of the house if the woman hadn't let me and I would have had to have gone for a warrant so they were very supportive they were very nice with the service user and she lets us back into the property freely and it went smoothly.

But, it could have been an awful lot different. So I can't speak highly enough of them there. It's the same in every profession you're going to get people who work with you.

C- And how to find the ambulance crew?

E- Mostly okay, it's a mixed be they understand our role more as the police, generally more so than the police I think because we have longer to talk to them to be quite honest and they ask more questions about what's going on, what section is the person on, the police is more at let's manage the risks.

C- So thinking about how referrals come to you?

E- It can be by the psychiatrist, can be by another professional, I'll be by the psychiatrist at the team, adding the referrals from other professionals are pretty good, because if it's been a care coordinator from our team, then we had a chance to have a dialogue about what's happening, and it's not usually something that happens overnight it's due to a build-up and then just as a care coordinator or a fellow professional, we can advise people to say, look at least restrictive before we go down that route, so it's probably more fluid way of actually coming to the decision that we need to go down Mental Health Act assessment with psychiatrist. Again, within that team it's a chance that dialogue with other professionals is very much a done deal or so they think because the recommendations done, but as I say less so within our team.

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Has it hampered you this question?

E- Yes, I've gone blank... Mental disorder and how they manifest especially when you're talking about nature and degree, and when it's appropriate to use the Act and how the illness will play out particularly with nature yes it's a good overview of mental disorder but that's also where we can pick the brains of the psychiatrists as well, because at the end of the day were not medical but we do have to have a good overview of it also medication, obviously not to the same level as the CPN for a doctor but certainly a good overview of what medication we use, and the side-effects and even dosage so if someone.

Mathew - Stage 1 Interview

It's a change of role for me, it's kind of self-preservation because if you're a nurse and if you're an AMHP it's kind of giving you two strings in a way, so there was some of that behind the thinking. But that wasn't the primary driver. I kind of like the legal side of things although I'm not big on it, I'm not going be a lawyer, or anything but, but I kind of wanted to develop that side pull that side in along training so such. Increase my overview of things, and it was obviously available if you were an AMHP. But, obviously within that, but I'd be coming as a nurse, but especially with working assertive outreach, more socially focused with how it works. Working in assertive outreach with creative engagement. We started off with
two social work AMHPs, who were the team, but quickly it developed into the AMHPs leaving, and there being no AMHPs or Social Worker coming, so the team kind of, if you will, become very nurse led. Then you then got a social worker who is doing this conversion appeal hearing he was doing that. So again, I still had somebody to tap into but we lost that AMHP and I felt we'd lost part of our identity. Not to say that we're medically focused because we were all nurses, we'd all worked there a while, and we'd have social roles. Then an opportunity came, got a phone call one day from a senior manager about what I wanted to do and what they thought I wanted to bring to the team. My view was my own career development. I always looked at that, you will, as how people (any) received on the wards, as AMHPs, by medics. It always kind of seemed to be, their opinion was valued bit more, now whether it is valued or received in a different way or ... I really did tend to get a little bit more listened, more to respect really. So they said they would support me, and so I went to the interviews, the interviews themselves were quite interesting. There were six people on the panel, had a social Care Team Manager, you, service user and carer. I took the one-year route and the way they said it to me was because you should actually be about that level. So, you can pull that across into learning and stuff. (That was in 2010), so I was the only nurse in a class of about 20. I think it was the first or second lesson that we had, and we were told that nurses can't be AMHPs by people on the course. So, I said, 'Okay, right, you sure of that opinion, what you backing that with.'

You're too medical, you do what doctors say? I don't think I was shocked, I was a bit like 'me?', and, 'you're the right person be on this course? If you like saying things like that.' So, I kind of turned it round and I just challenged that, so I said, 'I'm working in assertive outreach and that's a social team really. My primary role is to keep people out of hospital.' Consultant we had at that time was very good, he listened implicitly he would bend over backwards, he would do whatever. He wasn't a consultant in the conventional scene, where he... so from a medical perspective he would share responsibility, he was very social, socially orientated. You see... you had the ability to challenge decisions and to what was encouraged.

C - So did it feel like decisions were made collaboratively?
M - Definitely, as long as you had the evidence to back things up he would go with it.

C - By the end of the course what were with the views of the social workers towards you?
M - The views of the social workers then was different, I didn't hide at the back of the class, I wasn't up there by any means, but I was able to pull a different angle on it. There were times that the medical side of things, but I bring that medical knowledge into that social setting, so I think eventually people started to learn about me as well in a way. There was a man on the course previous, an ASW, very knowledgeable, he'd been very high up. He changed but he'd come back to AMHP, probably know more the majority of us, in fact he knew more than the lecturers. So, I've got that to pull from, knowing him and a couple more, I felt supported. By no means is that just happened to me, that, that's happened whilst I've been practising.

19:30.
On one occasion when I was doing a section 135(1) and an AMHP told me to go away, I didn't know what was he doing, I was a nurse. But I said, 'No problem, this is my view, this is how I would do it all, go back and speak to the manager.' So, he went away to court for section 135(1) and he got told, told to come back with the thing (warrant application). He got a ribbing for that. And a couple of times early on when you kind of sense that... Oh he's the token nurse kind of thing!, but as times gone on and relationships have kind of evolved, people change don't they, when they can actually understand that I can actually do the role. You know I'm not just sticking everybody in because the doctor says so! You know
the role itself that was there for just social workers, I think the training is different you know, we do come from different types of pills if you like, but we are integrated, we do crossover! These roles which we do as a nurse which would be social, and I'm in a crisis team are so I'm deputy manager for it, so we cover quite a large area, so it's quite a big patch and we have local AMHP meetings. There's three social workers, someone who's just trained as a nurse, and me who are AMHPs. There was kind of some, apprehensions from people maybe, but I think overall is gone by the by from me. Once in my role I identify myself as an Approved Mental Health Professional now I don't actually like that phrase, because I don't like the word professional.

C - Why not?

M - I don't know, I dislike it, it seems to give you the fountain of all knowledge probably, you're the one that knows, and if it's when you're discussing it with service users, I'm Approved Mental Health Professional, then to me feels scary, as it seems to me from the outset to give that aura of power. I don't like it. Now I know I need to use it because that's the role I'm taking. But I don't feel comfortable. So, I tend to at times say, 'That's my role but I'm also a Nurse. But I'm here to listen to you and understand what it is, so let's take that out of it.' It's a legal bit... So, I try to get that out of the way quickly really. It's like setting you up with an expert. I reviewed with a doctor in a particular area then yes, but I have a more wide ranging overview of things but...

C - Do you think it (AMHP) was a barrier between you and the service user?

M - An invisible one I think, I can try to look at it the other way round, of trying to experience that, you can't do that unless... That word 'professional' is harsh for me. If mental health practitioners that would be better to me but we are here under this role.

C - What's unique about the role?

M - Think that is unique is how your received, that you tend to get a different reception, in respect of how your listened to, you certainly get that from doctors, and stuff. Now that goes both ways whether the doctor can't wait to get you out of the room, or all the more open to that discussion because of because of or because you and stuff. I think even being known that you are renowned, even kind of being a nurse manager with the AMHP as well is kind of the questions you asked as well the direction you take for the advice and support. You tend to get people coming to you more often for that knowledge rather than I think necessarily if it was just me being in a CPN (Community Psychiatric Nurse) role. Sometimes I think you do go to most senior people to get experienced side of things, to try and get that knowledge so don't think it's a unique type of thing it identifies you a bit different does the role than a kind of like a generic practitioner if you will, give you a right or wrongly a different standing and how people kind of perceive that? That is how I feel at times. I'm not overly comfortable with that, because there are plenty of people out there that have chosen not to be an AMHP, but are very knowledgeable about the role in the sense of they've worked alongside it, been out on many assessments, so they got some knowledge, as well as that there are bloody good social worker or an OT or a nurse or a psychologist, right. Or they've been around various experiences as well. So, I think you can be an AMHP and be viewed differently, but I think at the same time from me also got to know your limitations and kind of not put yourself up there on a pedestal do you know what I'm trying to say?

C - Do know what you are trying to say.

M - The role though it brings everything, it tends to be legal issues. I think that people will query. Again, I had one yesterday from a practitioner, she spoke to my manager and then my manager asked me about 126 in A and E stuff, so it was what could we do around this and where could we go? And who do we go to, to make sure this doesn't happen again. So, though who you've worked with and stuff and you do kind of come into contact with a wider range of people just as an AMHP because you'll be working with like you say ambulance
Class

Caroline: So how has your class influenced your professional identity?

Tina: Well I’m working-class background, still am (laughs). And the service users all of them I have to work with are from a working class background, but I always thought, I think I would have worked in other areas, in South are kind of working with the ‘wounded well’ in a sense, I don’t mean that in an awful way. People who were ill and not to the degree of in a city where I work now and they seem to be treated differently. Even when we got a referral, if it was somebody who was say teacher or Prof or whatever, it would be; ‘well he’s very articulate’, almost like... be careful, his daughter works for whoever, be careful about this one and it was all about making sure you say the right thing to them at the right time, not just the fact they were poorly or they needed services but treating them with the degree of respect that they are due (said sarcastically). But I mean personally I just treat everybody the same, I treat everybody the same as I would treat everybody else. If there’s a complaint that comes in then we will deal with it as it arises, you constantly have a two-tier system (sighs). So that always stood out to me. Caroline: So, did you feel you related more to people from the same class background?

Tina: I don’t know and not thought about that... not really. All the same to me. Caroline: So, what is it about being working class that is influencing the way you work?

Tina: I think it comes back again to making sure that people get some kind of voice that they can speak, that there being listened to and being heard because sometimes that can get lost in it. And you might get people who are just totally kicking off, Caroline, you’ve seen it yourself and nobody wants to go near, and they’re not going to be heard as clearly, that was when I would say today things are a little bit better. I would say today things are a lot better by saying many years ago you wouldn’t want that kind of attitude almost like a discharge although too dangerous for...

Caroline: So, what is it about being working class that is influencing the way you work?

Tina: Caroline: So, what is it about being working class that is influencing the way you work?

Tina: I think it comes back again to making sure that people get some kind of voice that
Research

Time: It is quite common knowledge that black males you know make up the largest number of humans in secure units, that to me stood out when I first went to Ashworth in 1990. I went there and I thought cramps this is horrible, is just horrible. I think it was horrible because of the way some staff would speak to the patients, but it felt to me that that was prison, as soon as I walked in I felt like prison it felt like Strangeways just a bit more low-key. So, the attitudes of staff to the patients was horrible to watch. Some staff were lovely with a patient’s some were just so rough you wouldn’t think that they were in a hospital and seeing that the majority of people that I saw on one wing, I never understood why they called the wing, Moss side or different areas so I was thought it is named after Moss side because everyone on this board is black! It [laughs] and I was too shy to ask because I thought is that a daft question? It was very odd and I just never got a large number of black males.

Caroline: And how did that make you feel as a social worker then? Did you feel there were challenges that you needed to embrace?

Time: I think when you walk onto a unit like that they see you, you see them, and straight away you’re not here to help me anyway your part of the ‘them’ squad. Even if you are there as their advocate, you’re not seen as that, you’re seen as you’ll say what you want to say you are on the other side. So, very difficult sometimes to work with people even of the same race. I’ve had people black women say: ‘I don’t want work with her she’s a black female’.

Caroline: And what was that about?

Time: I’ve no idea – sometimes I have supervision and we talk about it and what would come out would be, well maybe they think because you live in a small kind of area you might know people that they know, but I don’t know anybody that you know and I don’t live round here. But it was just... They were being judgmental really, I’m black your black so I know all your friends.

Caroline: Have you encountered that much? I say on about one hand, and that’s in all 18-19 years. But when it happens it still makes you step back at bit, it still makes you gasp a bit. And the last time I had this was last week when I was on AMHPI duty in a in A and E and I was assessing as an AMHPI, and I thought; oh well, I’m here to hear your side of things, and they said; ‘I told you are not speaking to you’ and the language was pretty bad and the police officer was thinking I think you should move back love because it’s just not helping, she’s not going to speak to you, she is going to kick off in this cell and that’s what she did, not cell, but it does look like a cell the 136 suite. It’s not a suite really is it. And I hadn’t heard that in a long time and when it happened again I thought wow! How dated. But still she felt that she had to say that and I’ve never seen her before in my life [laughs].

Caroline: So, the research about black people being overrepresented in mental health services do you feel you are more of an Advocate to those people because you’re a black female or not?

Time: No I don’t feel any more an advocate than any white British, purple, yellow person anyone in my role would be no. Caroline: So, does your ethnicity come into the influences on your identity as such?

Time: No I don’t think so, I think sometimes you might go into different circles with colleagues more than where you might be the only black person in the room, fair enough that happens that’s not a new thing but apart from that I wouldn’t say it’s got any
Caroline: So, going back to the research hit. Has there been other things you've learnt from research that have influenced you as an AMH?

Tina: Gosh I read that many things... There's too many things. Policies everything, Everything changes at the drop of a hat, you turn your computer on I'll have 1000 emails, about something that is to do with capacity that's changed. I delete a lot lately, and I don't mean because it's important. I'll skim it but then think I'm having email overload! About capacity and about DfLa, it's just too much information. It needs to slow down, it really does. We know things are changing, it's showing me that a lot of people, the higher beings are not very clear about what they're doing really and that is quite unnerving. But that's not research that's government driven policy.

Caroline: So, think about the changes to the new Mental Health Act did that have any impact on the career influences?

Tina: No not really, it was good to know that these things were in black and white now. It didn't really change a lot of practice... Sure. In the stuff about advocacy with carers. I was looking out for them, we were always doing that anyway, but it's just making sure that you actually tick the box now, but you were ticking it before... do you see what I mean but it's written in black and white now. Everyone is more exact now. When you've been doing it for X amount of years I can't think of anything that really changes for me.

Caroline: How do they influence you? I think the first day that I joined the mental health team I had S and then there was C and M and I was watching the way that your team, you hadn't arrived yet but watching the way they worked. They started off in X and I thought 'oh, don't they get on really well'? I thought this is really interesting to watch because you don't do anything and I remember S giving me a stack of policies or something to read keep me quiet in the corner. I thought I can't read this all day, it's just too much. I was just people watching them and I felt this is interesting. And everyone seemed to be bouncing off ideas on each other when I was thinking that's a good thing because I was thinking oh god I'm going to be all on my own. I'm going to have to do all these things and be the great social worker and pretend to be anyway, that's the first day you know Caroline and all that's running through my mind. But watching that team spirit I thought mm, this is a very nice team isn't it. The way that you work together and support, the support was there. And I think one person that influenced me was T, he hung on with him before he was team manager we used to sit facing each other and M, the team was very, very interesting to watch. Because everybody had a different way of working, they didn't mind being different, it was great being different, not been the same. But going out with all of them individually and seeing how they practice. I just saw that nice that no one's the same here, it's like putting your hand in a tin of Quality Street but always coming out with a very good result! Lots of laughs. 35 cases!! Laughs. But it was T, quite liked his practice when I saw a man of the people, but I just thought he is quite clear even though he goes in a state, a bit too last, maybe a bit too casual but he comes back and what he can tell you about what he has learnt from that visit, you wouldn't think he'd have learnt all of that in that half an hour and so he kind of showed me that listening is the key as well. You need to focus and he was good advocating on people's behalf. How? Even when they didn't have something he would suggest that they have it. Even when someone is moved into a flat they didn't even know about you into care grant he would suggest that they have it. That's something that he does that or shall we apply for DLA. Yes, he would tell them all the things they were missing out, he wasn't working he was very good, very clear and very good with the families.
Appendix Q – Terminology

ASW – Approved Social Worker (former MHA applicant role prior to AMHP)
AMHP – Approved Mental Health Professional
BIA – Best Interest Assessor, a legal role under the Deprivation of Liberty Safeguards
CMHT – Community Mental Health Team
CPA – Care Programme Approach
CPN – Community Psychiatric Nurse
DoLS – Deprivation of Liberty Safeguards
HCPC – Health and Care Professional Council
NWoW – New Ways of Working policy document
OT – Occupational Therapist
MHA – Mental Health Act 1983 and amended in 2007
MHAA – Mental Health Act Assessment
MCA - Mental Capacity Act 2005
NPM – New Public Management
PNPM – Post New Public Management
RC – Responsible Clinician (usually a psychiatrist)
S.12 Doctor – a GP or Psychiatrist approved by the MHA to undertake mental health medical assessments.
SW – Social Worker
TCSW – The College of Social Work (replaced by the HCPC as the regulatory body for social work registration)
Appendix R

Additional duties include but are not confined to:

- Entering and inspecting premises where a mentally disordered person lives if it is believed that the person is not under proper care (section 115)
- Applying for a warrant from the courts to enter and remove a person where this is needed to undertake a proper assessment (section 135)
- To convey the person to hospital where they will be admitted (section 6(1))
- To agree to the making or extension of a community treatment order (section 17a and b))
- Informing or consulting with the nearest relative about an application (s.11, MHA, 1983)
- Providing a social circumstances report for the hospital managers or Mental Health Tribunal (s.14, MHA, 1983) for a patient detained, this is a detailed report on areas of an individuals’ social history, diagnosis, risk factors, finances and benefits and housing situation, providing a holistic picture of an individual.
- Confirming that a Community Treatment Order should be made and agreeing to any conditions (s.17A, MHA, 2007). Agreeing an extension of a Community Treatment Order (s.20, MHA, 2007) or to a revocation of a Community Treatment Order (s.17, MHA, 2007)
- Displacement or appointment of nearest relatives (s.29, s.30, MHA, 1983). Applying to a county court for nearest relative displacement and or the appointment of an acting nearest relative (s.29, MHA,1983)
- Conveying a patient to hospital (or a place of residence) based on an application (s.6, AMHPs have a wider role than doctors within the act, who make the medical recommendations for detention for assessment (s.2 MHA, 2007) or detention for treatment (s.3 MHA, 2007), particularly, as the applicant for detention, where they must carefully consider any wishes expressed by relatives and any other circumstances:
Dear Caroline,

Good news. I have spoken with [redacted] today, and she has confirmed that you have approval to include AMHPs within nursing. Please take this email as confirmation of approval.

Kind regards

Please note I do not work Mondays. If I am away from the office, voicemail will be switched on.

Tel: [redacted]
24.10.2014

Dear Caroline,

Please take this email as confirmation that you have permission for the involvement of OT to be involved in your study, as per the proviso below.

Kind regards

Please note I do not work Mondays.
If I am away from the office, voicemail will be switched on.

Tel: 
Email:

Hi

In principle, I’m Ok with this. I think we only have one OT in the Trust who is doing this role and who could be interviewed. I would just want the OT to be able to say if she has the capacity to get involved in this at the moment.

Best Wishes

Tel:
Email:
Dear Caroline,

Further to the review of your research project ‘Shifting identities – How do Approved Mental Health Professionals develop their professional identities and what are the influences and professional features that shape this?’ I can confirm that this has received Trust permission.

Once I therefore receive your completed research passport I can issue you with the Trust permission letter, along with the letter of access.

Regards

Beverley

Beverley Lowe
Research & Development Senior Officer
Research Department
Corporate Directorate
Lancashire Care NHS Foundation Trust

(01772 773498
(07508 601925
Name of Trust

Project Reference: 14/25  Project Title: Shifting identities–How do Approved Mental Health Professionals develop their professional identities and what are the influences and professional features that shape this?

I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however, you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Please make sure that you take your Trust permission letter with you when accessing Trust premises and please include the Trust reference number on any correspondence/emails so that the services are assured permission has been granted.
13th October 2014
Mrs Caroline Leah  Lecturer  University of Manchester Applied Mental Health Course
School of Medicine

Room 1.1 Simon Building Brunswick Street Manchester, M13 9PL

Dear Mrs Leah,  Re: NHS Trust Permission to Proceed

Honorary Research contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that directly affects the quality of their care, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (Research Governance Framework for Health and Social Care, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research MUST be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is The University of Manchester. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv  For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.
Good Clinical Practice (GCP)

GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. Please note that student projects are exempt from this process.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within Lancashire Care NHS Foundation Trust you must adhere to trust policies and procedures at all times.

Confidentiality and Information Governance

All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998). For good practice guidance on information governance contact us.

Protocol / Substantial Amendments

You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details

If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However, if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.

Recruitment
Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders. You may also be invited to present your findings to the Trust at an event or meeting.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,

[Redacted]

On Behalf of the Research Governance Sub-Committee

Cc: Name
To whom it may concern

This is to confirm that where appropriate the insurance policies held by the University of Manchester will apply to the research entitled ""Shifting Identities – How do Approved Mental Health Professionals develop their professional identities? What are the influences and features that shape this?" which we have been informed is being conducted by Mrs Caroline Leah under the academic supervision of Professor Alan Dyson.

The University has insurance available in respect of research involving human subjects that provides cover for legal liabilities arising from its actions or those of its staff or supervised students. The University also has insurance available that provides compensation for non-negligent harm to research subjects occasioned in circumstances that are under the control of the University.

Provision of this insurance cover in respect of a specific project may be subject to the acceptance of the project by the University’s insurers and is conditional upon the project receiving approval from an appropriate ethics committee.

Signed on behalf of the University of Manchester,

Mohammed Zubair
Research Governance, Ethics and Integrity Officer

Dated: 25th September 2014
Appendix T

Initial Recruitment Email

Sent: 03 November 2014 12:08
To: X
Subject: AMHP Research - Stage 1

Hi X,

How are you? I have now received my University ethical approval and approval from X to recruit Social Work AMHP participants to my study and am writing to invite you to be one of my participants. I am attaching the study information for you to consider as a potential participant. Once you have read it please let me know if you have any questions about your potential participation. If you decide to be one of my participants (and I really hope you do!) then please let me know if you would like me to come to you for the interview (we would need an interview room) or if you want to come to the University for interview. Below are some potential dates for us to meet:

Monday 10th Nov - anytime between 9.30am -3pm.
Tuesday 11th Nov - anytime between 9.30am -2pm.
Monday 17th Nov - anytime between 9.30am -3pm.
Tuesday 18th Nov - anytime between 9.30am - 2pm.
Wednesday 19th Nov - 9.30am -12.30pm.
Monday 24th Nov- 9.30am - 2pm.
Tuesday 25th Nov - anytime between 9.30am- 1.30pm.
Thursday 27th Nov - anytime between 9.30am -3pm.
Tuesday 2nd Dec - anytime between 10 am -1.30pm
Monday 8th Dec - anytime between 9.30am -3pm.

Please let me know if you’re happy to go ahead and if you are if any of these dates are suitable.

Kindest

Caroline.

Kind Regards
Caroline Leah | Lecturer |
PG Cert/MSc in Applied Mental Health | 1.11 Simon Building | The University of Manchester | Manchester, M13 9PL | Tel 0161 2755851
Please note I work part-time (Monday, Wednesday and Thursday)

Endorsed by
THE COLLEGE OF SOCIAL WORK
The voice of social work in England

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Stage One Email

Sent: 24 November 2014 10:26
To: X
Subject: AMHP Research - Stage 1
Attachments: Thesis topic guide; Stage 1 topic questionnaire.

Hi X,

How are you? I have now received my ethical R and D approval from X, so would like to arrange to see you for interview. I’m really pleased that you’re interested in this. I am attaching my study participant information sheet and stage one interview topic guide for you to read and consider if you would still like to take part in my project. If you have any question please let me know and we can discuss when convenient for you. These are the following dates I’m available – I can come to you and we will need a quiet interview room or you can come here. So, let me know what suits you best? It will take approx. 1 hour.

Dates/times:

Tues 2nd Dec – between 10.30am - 1pm
Mon 15th Dec – between 10.30am - 2pm
Wed 17th Dec– between 10.30am - 2.30pm
Thurs 18th Dec – between 10.30am - 2.30pm.

Any good? If not, we can look to January.

Kind Regards
Caroline Leah 1 Lecturer 1
PG Cert/MSc in Applied Mental Health 1 1.11 Simon Building 1 The University of Manchester 1 Manchester, M13 9PL 1 Tel 0161 2755851
Please note I work part-time (Monday, Wednesday and Thursday)
Hi X,

Hope you are well? Can I trouble you for an interview soon, next time it’s influences on your career that I would like to talk with you about. I attach a topic guide for your information and let me know if you would like to discuss this further. Are any of the dates/times below good for you? I can come to you or you can come here whatever’s best for you.

Look forward to seeing you.

BW

Caroline.

Wednesday 22nd April – 2pm.
Thursday 23rd April – between 10am -1.30pm.
Thursday 30th April – between 1pm -3pm.
Wednesday 6th May – between 10am -2pm.
Thursday 7th - between 10am - 2pm.

Kind Regards

Caroline Leah 1 Lecturer I Unit Lead for Applied Psychiatry, Research Methods, Children with Complex Mental Health Needs and MSc in Applied Mental Health
PG Cert/MSc in Applied Mental Health 1 1.11 Simon Building 1 The University of Manchester 1 Manchester, M13 9PL 1 Tel 0161 2755851
Please note I work part-time (Monday, Wednesday and Thursday)
Hi X,

How are you? Hope all is good at work. I’m at the final stage of my research interviews now and this will be the very last one. In this interview, I want to explore AMHP hybridity, that is how AMHPs’ professional work similar or dissimilar to other professional’s work, such as judge. I attach the topic guide for your information and do let me know if you would like to discuss this any further before we meet. The interview should take no longer than a one hour.

Can you do any of the following dates/ times?

Mon 19th Oct
Tues 20th Oct
Tues 3rd Nov
Fri 6th Nov
Mon 9th Nov

Let me know – thanks and look forward to seeing you.

Kind Regards
Caroline Leah 1 Lecturer 1 Unit Lead for Applied Psychiatry, Research Methods, Children with Complex Mental Health Needs and MSc in Applied Mental Health
PG Cert/MSc (incorporating AMHP and BIA training) in Applied Mental Health 1 1.11
Simon Building 1 The University of Manchester 1 Manchester, M13 9PL 1 Tel 0161 2755851

Please note I work part-time (Monday, Wednesday and Thursday)
Appendix U – Exemplar email for demographic data

23rd March 2017

Hi [name]

I hope you are well.

I am now almost ready to submit my thesis and just need a couple of things from you please.
  • Your DoB
  • Number of years as an AMHP
  • Your professional roles
  • Ethnicity

If you could let me know by the end of March that would be great.

Please reply to my new work address copied in above - MMU.

BW

Caroline
Appendix V – GSCC Demographic data

Figure 1

AMHPs by Profession

- SW's
- Nurses
- OT's
- Psychologists

Figure 2

AMHPs by ethnicity

- Asian British & Pakistani - 10
- Asian British-Indian - 22
- Other Black - 1
- Black British - African - 76
- Black British - Caribbean - 64
- White - 697
Figure 3

AMHPs by gender

- Female: 70%
- Male: 30%

Figure 4

AMHPs by age

- 25-34
- 35-44
- 45-54
- 55+
Access to my sample

I will request access to my sample of Approved Mental Health Professionals who work in the North West of England. I have decided to limit the geographical area due to issues of cost and time travelling and because I have professional relationships with the Heads of Social Care (the gatekeepers) who manage AMHPs in the North West of England. Access to my sample will include discussion with and approval from Heads of Social Care and AMHPs. AMHPs will be invited to participate by email and telephone contact.
## Appendix W – Hybrid types

### Dominant ‘Perspectives in use’

*Ranked by occurrence and emphasis within the data - XXX strongest (more than 5 examples), xx – 4 examples to x weakest 2 or less examples, no. 0 - indicates not present.*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Social</th>
<th>Legal</th>
<th>Psychiatric</th>
<th>Psychological (Therapeutic)</th>
<th>Type of hybrid perspectives that are dominant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annette SW (Illustrated)</td>
<td>xxx</td>
<td>xx</td>
<td>xx</td>
<td>0</td>
<td>Social-legal psychiatric (SLP)</td>
</tr>
<tr>
<td>Elizabeth SW</td>
<td>xxx</td>
<td>xx</td>
<td>xx</td>
<td>0</td>
<td>Social-legal psychiatric (SLP)</td>
</tr>
<tr>
<td>Simon Nurse</td>
<td>xxx</td>
<td>x</td>
<td>xxx</td>
<td>0</td>
<td>Social-legal Psychiatric (SLP)</td>
</tr>
<tr>
<td>Kate SW (Illustrated)</td>
<td>xxx</td>
<td>xx</td>
<td>x</td>
<td>0</td>
<td>Social-legal Psychiatric (SLP)</td>
</tr>
<tr>
<td>Bernie SW (Illustrated)</td>
<td>xxx</td>
<td>xx</td>
<td>x</td>
<td>0</td>
<td>Social-legal psychiatric (SLP)</td>
</tr>
<tr>
<td>Tina SW</td>
<td>xxx</td>
<td>x</td>
<td>x</td>
<td>0</td>
<td>Social-legal psychiatric (SLP)</td>
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<tr>
<td>Matthew Nurse (Illustrated)</td>
<td>xxx</td>
<td>x</td>
<td>xx</td>
<td>0</td>
<td>Social-psiychiatric legal (SPL)</td>
</tr>
<tr>
<td>Diana SW (Illustrated)</td>
<td>x</td>
<td>xx</td>
<td>xxx</td>
<td>0</td>
<td>Psychiatric-legal Social (PSL)</td>
</tr>
<tr>
<td>William SW</td>
<td>xxx</td>
<td>xx</td>
<td>x</td>
<td>x</td>
<td>Social-legal psychiatric-therapeutic (SLP)</td>
</tr>
<tr>
<td>Dawn OT (Illustrated)</td>
<td>xx</td>
<td>x</td>
<td>x</td>
<td>xxx</td>
<td>Therapeutic social-legal (TSL)</td>
</tr>
</tbody>
</table>
# Appendix X - Hybrid key ideas used as thinking tools

<table>
<thead>
<tr>
<th>Hybrid roles</th>
<th>Hybrid identities</th>
<th>Hybridity</th>
<th>Hybridisation</th>
<th>Boundary crossing</th>
<th>Interdisciplinary work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed roles</td>
<td>Mixed identities, cultures (e.g. medical, social, psychological professional perspectives) A new form of identity that emerges because of a combination of different types of identities. Increasing forms of hybridity as identities becomes more complex.</td>
<td>Is a mixture of mixed prof origins, crossovers. Hybridity often suggest belonging to multiple worlds at the same time ‘plural worlds’.</td>
<td>The process by which hybridity is negotiated, enacted, achieved, visible.</td>
<td>Social interactions with colleagues such as psychiatrists, GPs, police, lawyers and dialogue where professional identities are enacted.</td>
<td>Within MHHA.</td>
</tr>
<tr>
<td></td>
<td>Strong features.</td>
<td>Mixed prof roles</td>
<td>Embedded in professional roles.</td>
<td>Developed competence outside singular prof role – crossing prof jurisdictions.</td>
<td></td>
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<tr>
<td></td>
<td>Feeling of belonging to an in-group.</td>
<td>This mixture is enacted in dialogue, in spaces where AMHPs absorb other professional disciplines knowledge, skills, values, ideologies (e.g. social v medical ideologies).</td>
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<td></td>
<td>Embrace a breath of perspectives and integration of different ideological stances.</td>
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<td></td>
<td>Values of social justice, ADP strongly applied and used to challenge medical model. Strongly identify with legal aspects of role.</td>
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<td>Strong use of dialogism to negotiate hybridity and cross professional boundaries to achieve positive change/shared goals, outcomes</td>
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<tr>
<td>Move from a pure professional role to a mixed professional role.</td>
<td>Hybrids straddle number of roles</td>
<td>Cross-cut traditional boundaries</td>
<td>Social interactions with colleagues such as psychiatrists, GPs, police, lawyers and dialogue where professional identities are enacted.</td>
<td>Within MHHA.</td>
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<tr>
<td>Creative boundary crossing to achieve best outcome for service user.</td>
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<td>Positive risk taker</td>
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<td>Skilled at working with inconsistency/complexity/ambiguity</td>
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<tr>
<td>Strong pragmatic collaboration between different prof roles and organisations. State, service user, market.</td>
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<td>Skilled in conflict management</td>
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<td>Examples of sophisticated boundary crossing.</td>
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<td>Strong autonomy</td>
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<td>Independence</td>
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<td>Shift and sort large amounts of complex information, involving knowledge of best practice in multiple fields.</td>
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<td>Enforce legal duties.</td>
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<td>High degree of relational agency</td>
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<td>Non-hierarchal facilitative leaders</td>
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<td>Divergent views conciliated and enacted dialogically</td>
<td></td>
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<tr>
<td>Pure</td>
<td>How identities are performed and foregrounded?</td>
<td>In the type of work AMHPs do that has belonged to other professionals ‘jurisdictions’ traditionally and is now incorporated</td>
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<td></td>
<td>Weak features</td>
<td>In the sense of expansion of primary professional role and what happens when professional identities that are incompatible get mixed up. Impact of this on professional identities.</td>
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<td>Weak sense of belonging to an in group, few feelings of affinity</td>
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<td></td>
<td>Little enactment of social justice, ADP in their practice, only identify with strict parameters of the AMHP role. More likely to use social perspective than a BPS perspective.</td>
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<td>Not confident in seeking creative solutions ‘habitual’</td>
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<td>Seek certainty in the role.</td>
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<td></td>
<td>Hybrid identity as integrating other professional disciplines knowledge working in integrated structures.</td>
<td>Professional and managerial principles, what is dominant in terms of the control of work?</td>
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<td></td>
<td>Perhaps it is a contextual identity that, when pressed or nurtured, emerges and makes the two or more</td>
<td>Institutional practice What do AMHPs create outside of</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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parts that the hybrid consists of fuse into a third entity. It is a breaking of the two, yet also a merger at the same time.

| their defined role? What do they maintain, hold onto as a key feature of their jurisdiction; what do they disrupt, challenge, negotiate through dialogism? |  |  |  |