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Title: The Role of the Approved Mental Health Professional: A 'Fool's Errand'?

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Keywords

Approved Mental Health Professional; 'Fool's errand'; Irony; Mental Health Act; Mental Health; Professional Practice.

Abstract

This article explores the concept of a 'fool's errand' in relation to the specialist role of the Approved Mental Health Professional (AMHP). An AMHP has a duty to make an application following a Mental Health Act assessment (MHAA) to detain and admit an individual to a psychiatric hospital. Findings from a qualitative study of ten multi-professional AMHPs in England, suggested AMHPs were subjected to a 'fool's errand', when they were asked by psychiatrists and bed managers to practice in a way, they, themselves, considered unwise or foolish and that did not make sense in the context of their role. The author will illuminate how false starts and delays in securing treatment and care outcomes for mentally unwell individuals compromised AMHP practice.

Focus and Findings (Teaser Text)

The vast majority of AMHPs in England and Wales are social workers, the AMHP role is therefore an important part of the work that social workers do. AMHPs assess individuals with mental disorders making sure individuals assessed under the Mental Health Act (MHA)

are appropriately supported to recover from an episode of mental illness. The AMHP role requires AMHPs to work as part of larger multidisciplinary teams, in situations that are risky, and complex. The concept of the 'fool's errand' is applied to show how AMHP work involves delays to safely transporting individuals to hospital and delays in identifying patient beds, leading to delays in hospital admission. This had a negative effect on how AMHPs perceived their role. To manage the effect of negative delays, it was found that AMHPs acted in ways that enabled them to dismiss policies or challenge other professionals ways of working, e.g., bed managers, that were not favourable to supporting individuals to be safely detained under the MHA. The findings suggest that AMHPs should be better supported to make independent decisions, within organisational policy frameworks, that facilitate, rather than constrain their role.

Introduction and background

Whilst literature on occupational roles has highlighted the complex challenges of occupational groups acting as either generic or specialist workers (e.g., see Nathan and Webber, 2010) such debates are arguably less relevant now due to the increasing focus and recognition of public sector workers as hybridised professionals (Leah, 2020); Noordegraaf, 2007, 2015; Spyridonidis *et al.*, 2015). Similarly, research on how professionals enact their resistance to work based decisions by others whom they work with, to meet the needs of people with complex care and health presentations, as hybridised professionals, has not been fully developed in the sociology of professions (Edgell and Granter, 2020). Nor has research fully examined how AMHP roles are contextually and situationally adapted in workplace interactions or considered how broader structural contexts interact with AMHPs' subjective perceptions of their role and practice.

For a profession dedicated to supporting service users in mental health crisis, there are few studies that have examined actual role enactment and unlike this article, none from the perspectives of multi-professional AMHPs. Although, some of the challenges and tensions

surrounding the AMHP role have been explored. For example, AMHP work as 'dirty work' (Morriss, 2016; Vicary *et al*., 2019) its 'invisibility' (Morriss, 2017), and 'hybrid identities' (Leah, 2020). Even so, AMHP perspectives of their role, including the attitudes and values attached to that role, and how the AMHP role is applied in work-based interactions has yet to be examined. Additionally, research that foregrounds the conflicts and tension that can occur between professional groups with differing ideological positions, such as those between Approved Clinicians (Oates *et al*., 2018) and AMHPs is worthy of consideration. Hall (2017) for example, highlighted the challenge faced by AMHPs separating medical problems from social problems, questioning the purported dominance of a social perspective as a jurisdictional claim for AMHPs. He stated, like Morriss (2017), that mental health practice in the UK today is still dominated by a medical model. In similar ways to this article, Hall (2017) was interested in AMHP practice 'as is'.

Within this article, this means the AMHP role as it is enacted, observed, perceived, and interpreted during MHAA, therefore, reflecting the reality of an AMHP's daily practice (Evans, 2008; Leah, 2020). Professional practice to be meaningful, must illuminate the everyday practice realities of professionals (Leah, 2020, Evans, 2008; Hoyle and Wallace, 2007). Accordingly, this article may have a broader conceptual application to other public sectors workers nationally and internationally where the experienced realties of professional work differ from the codification of professional roles via competencies, capabilities, or practice frameworks.

The AMHP role has been under a great deal of pressure over recent years (DHSC, 2019) and one of the findings of Health Education England's (2019) new roles research is that it has not had the same national attention and support that other senior professional roles have. Prompted by concern at the rising number of patient detentions, (a 20 per cent rise between 2014 and 2016) (CQC, 2018; ADSS, 2018) including the disproportionate detention of black and minority ethnic people, and the current review of the Mental Health Act in

England and Wales, (DHSC, 2018), this study is especially timely in its examination of the AMHP role given the White Papers recommendation that cultural change is of paramount importance for improving patient experiences and care under the Act (DHSC, 2021).

AMHP work

The role of the AMHP is one of the most important and senior professional roles in mental health services, operating across services, over 24-hours a day and working alongside many other professionals**.** The AMHP role applies to multiple professions who practice in different environments. In England and Wales, the AMHP role can be undertaken by social workers, mental health and learning disability nurses, specific psychologists, and occupational therapists, although 95 per cent are estimated to be social workers (Carson, 2018). The AMHP role in the legal sense requires a duty to assess and consider the application for admission of an individual under the Mental Health Act (Section 13, MHA 1983) based on social and medical evidence (Department of Health, 2015, 14.52). The broader aspects of the role involve deciding for the patient to be conveyed to a hospital bed, when detained (Department of Health, 2008). This involves working with bed managers and two section 12 approved doctors during the assessment to identify a suitable bed if detention is agreed. To be detained under the MHA the patient must be suffering from a 'mental disorder' of a nature or degree which requires the patient to be in hospital for either the patient's own health OR safety or in the interest of public protection.

The AMHP has a fixed legal role to negotiate and manage an admission to hospital, if community alternatives to hospital admission are not appropriate, by collaborating with a multitude of professionals and across health and social care organisations. S/he has intellectual ownership 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, in areas of interprofessional action and involves inter-professional conflicts (Campbell and Davidson,

2012). Such issues of multiprofessional tensions can be usefully illuminated by drawing on the concept of the ‘fool’s errand’.

A Fool’s Errand

A fool’s errand has its origins in texts from the 18th century and was commonly used to mean 'futile' or ‘unwise’. In lay terms, a ‘fool’s errand’ means a foolish undertaking, particularly one that is nonsensical, or certain to fail, that involves an individual participating in a task which is known by that individual to be a waste of one’s time or unwise but despite this knowledge is still carried out by the individual against their better judgement and in the knowledge that the action or the ‘errand’ is unlikely to be successful. It was applied in Willis’ (2001) work “Tekin’ the piss” that focused on Percy, a working-class man’s, self-perception and his participation in ‘contentious local practice’, on the factory floor in 1970’s English Midlands (Willis, 2001 in Holland and Lave, 2001). A ‘piss take’ was a practical joke played on novices who were tricked into running a ‘fool’s errand’, in this case the errand of a fooled worker. In Willis’ (2001) analysis of the ‘piss take’ running a ‘fool’s errand’ becomes a form of irony, that was witnessed by Willis (2001) through his observations of workers’ localised practice. In this working reality, individuals were:

> ...abandoned in, trapped in or projected into the shadowy reality... [These] are ways different from the officially sanctioned ones of being and doing, even in the most controlled of situations. p.198.

A ‘fool’s errand’ was a way that individuals had their work compromised, when they deviated from working policies and procedures that gave formal meaning to the work undertaken. The work was played out within enduring power struggles and through the complex relations by which work based decision are operationalised (Willis, 2001). This concept offers an interesting way to understand the non-standardised approaches to contextually driven work encounters in relation to AMHP practice. Related to the idea of the fool’s errand is the opposing concept of the ‘cloak of conformity’ (Edgerton, 1993). This concept is a

metaphorical symbol that creates a façade of the ways professionals learn to adapt their practice when subjected to an a 'fool's errand' from which they cannot openly deviate without their practice being subjected to scrutiny (Fleming and Spicer, 2003). As Lipsky (1980) argued, how policy was enacted by professionals may deviate from how policy was formally intended to be applied by policy makers, because 'street level bureaucrats' will interpret its instruction in an applied way to enact work-based decisions in situations of risk, ambiguity and uncertainty (Evans and Harris, 2004). Egerton's (1967) 'cloak of conformity' therefore, has conceptual relevance to the study of professional roles, particularly in providing an explanatory concept to understand acts of subtle worker resistance, that are visible when professionals exercise professional discretion 'under the radar', involving 'bending' or ignoring the rules through the exercise of ironic practices.

Ironies of representation and ironies of adaptation

There are two main types of irony in the workplace, defined by Hoyle and Wallace (2007) as 'Ironies of representation' and 'Ironies of adaptation'. 'Ironies of representation' are where AMHPs present an image of the organisation to others that is misaligned with the reality of the organisation's daily practices. This representation is used to give the appearance of meeting the requirement of the role as it is understood within policies of mental health and social care organisations. The audience to whom this image is presented in this article included psychiatrists, and bed managers. Whilst, 'ironies of adaption' describes how professionals reconcile the competing expectations of different professional groups through improvised and negotiated actions delivered by AMHPs to best meet the perceived needs of service users in complex situations (Hoyle and Wallace, 2007).That is, in circumstances where AMHP practice is adapted because of false starts and delays in securing a hospital bed, and when AMHPs have difficulties in securing appropriate patient conveyance to a hospital because of different police and ambulance priorities.

Methodology

This research was informed by an examination of AMHPs from nurse, social work and occupational therapy primary professional backgrounds (Evans, 2008), as hybrid professionals (Noordegraaf, 2007). Using an intrinsic case study approach (Yin, 2014), the main field work was drawn from face-to-face semi-structured interviews with ten multi-professional AMHPs from three social care and mental health Trust sites in the Northwest of England. The Trusts provided mental health services to a mix of rural, suburban, and urban locations.

Recruitment and procedure

The study used purposive sampling (Padgett, 2017) with all participants being qualified and practising AMHPs. AMHPs working in the local service were sent an email, with the study information sheet attached, explaining the purpose of the study and requesting those interested to contact the researcher directly on their e-mail address. Those who volunteered were contacted to discuss the study, raise any questions about the research, and arrange a time and date for interview if they agreed to participate. Interviews lasting up to one hour took place in a private room at a university site. A topic guide for the semi-structured interviews was informed by a literature review of professional identities, professional socialisation, professionalism, hybridisation and the AMHP role (Noordegraaf, 2015; Webb, 2017). Each interview was audio recorded, with permission, using an encrypted device and transcribed verbatim by the researcher.

Confidentiality and Consent

Informed consent was obtained from all interviewees via a signed consent form completed prior to the commencement of the interview, following discussion of the study and topic guide. Interview data was anonymised at the point of transcription, with interviewees identified by a pseudonym. All data was stored securely on an encrypted University server. Participation in the research was voluntary. During the recruitment process AMHPs were

informed that participation would be kept confidential, their data would be anonymised, and nobody in the Trust would be made aware of who had taken part or what any individual had said. The study was approved by a University Research Ethics panel (PGR-73612820).

Table 1: Characteristics of participants

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

Data Analysis

Professionals render their lives meaningful through stories. Narratives are therefore useful for gaining an insight into how professionals interpret their place in the world of practice (Ricoeur, 1984). Analysing professionals' narratives is useful as narratives are made up of past experiences that enable people to make sense of the present (Riessman, 2008). Their relevance relies on bringing the researcher closer to practice. The author defined narratives within this paper as recorded, transcribed stories which have become units of interpretation. Interpretivist epistemology shaped the approach, with the stories interpreted as rooted in a time, context and working culture (Ahmed, 2013).

Language is a cultural resource that AMHPs drew upon, it reflected practice perspectives and the context in which professionals practice. In bringing the past into the present through language, utilising Bakhtin's (1981,1990) term, 'heteroglossia', the author interpreted AMHPs narratives of the 'fool's errand' by coding and theming data that had examples of AMHP practice where the AMHP for example was asked to do something that was against the Code of Practice guidance e.g., find a patient bed or act in a way they considered to be unwise and or even risky. Irony' was also applied as a concept for connecting AMHP working practices of the 'fool's errand' and was interrelated with the 'cloak of conformity' to explain subtle forms of AMHP resistance to certain courses of actions or decisions promoted by bed managers (Willis, 2001; Hoyle and Wallace, 2007).

Irony, as a theme, was noted in examples of practice improvisation, where AMHPs narrated how they improvised to achieve a desired outcome in their practice encounters with others. For example, professionals often negotiate who should do what in the workplace and this is not always 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, but administrated by bed managers, however, in reality AMHPs and bed managers negotiate

both the identification and availability of a suitable hospital bed for the person being detained (CQC, 2018).

The author examined the content of what was said, addressing the 'who' in the narrative and how events were storied by AMHPs. During interviews AMHPs were asked about their experiences of working on MHAAs. They were encouraged to share any opinions or ideas in relation to policies and practice guidance, both local and national that impacted upon their work. In turning the spotlight on professional practice, the author was concerned with the dilemmas experienced by AMHPs. A reflexive approach was adopted throughout the study to examine the potential impact the author's positioning, as an AMHP educator, held in relation to the participants.

Coded data were then summarised and charted in Word, with themes identified and systematically analysed by drawing on the five main stages in Framework Analysis (Ritchie and Spencer, 1990). Pseudonyms for participants will be used hereafter. Extracts from the data will inform the discussion of the key findings. This will be followed by a discussion and consideration of the potential implications for AMHP practice.

Findings and discussion

This next section will examine the concept of a 'fool's errand' and work-based ironies using extracts from interview data (Willis, 2001, in Holland and Lave, 2001, p.12), presented under the following two headings: 'identification of hospital beds' and 'tensions in multi-professional working and the AMHP's role'. This is followed by a discussion of work-based resistance and identities. In the first excerpts, AMHPs' issues in identifying a hospital bed, particularly with bed managers, are illustrated.

Identification of hospital beds

Tina, in the excerpt below, emphasises her frustration with her organisation's system of seeking permission from a bed manager to provide a patient bed:

> *To waste time phoning a bed 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 (bed managers) can't answer that question because they are not there. It's silly (Tina, Interview 1*).

Tina describes a local policy where the bed manager, rather than the AMHP, is required to phone the ambulance. Therefore, she had to seek permission from the bed manager to relay the information when it would be more efficient and less open to misinterpretation if she could do this herself. Psychiatrists have a duty to find an appropriate hospital bed and for a section 3 (MHA,1983) must indicate that suitable treatment is available, however, in recent years, this duty has been delegated to bed managers. A key element of the bed management role is to manage bed capacity, including bed availability. Bed managers should ensure that admission to a bed is timely and appropriate to meet the needs of the person being admitted (Code of Practice, 14.77). If necessary, a private in-patient bed can be allocated. This is a common occurrence due to well documented bed shortages (Acute Psychiatric Care, 2015). AMHPs are expected to take on board the risks and liability associated with being unable to comply with legal frameworks that equally apply to other professionals who work for health and social care organisations. Clinical Commissioning Groups (CCGs) have the power under s.140 of the MHA (DoH, 2008) to monitor and make provision for beds to be available, arguably they are responsible for not complying or adhering to this power.

The lack of inpatient beds is experienced by AMHPs as causing an unnecessary time delay that detrimentally affects individuals in crisis and furthermore places service users at undue risk. Through completing an assessment without a bed being available AMHPs are subjected to running a 'fool's errand', because it is wasting their time, when they must leave individuals in a mental health crisis at home. This often involves returning to same service user in subsequent days once a bed is made available. The same AMHP may return, or it may be reallocated to a new AMHP to arrange the service user's hospital admission. The

individual requiring hospitalisation, is therefore left at risk and liable to detention due to the lack of bed availability. In Morriss' (p.6, 2016) study she found that 'the lack of beds was more frustrating than the social control element' of the AMHP role.

Whilst AMHPs aimed to prioritise service users' needs within the assessment process, it was suggested by participants that other professionals, e.g., psychiatrists and bed managers placed their own priorities 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).*

Uncertainty about how psychiatrists would respond to their MHA duties was characterised by participants (to some extent) as the result of deliberate acts, sanctioned 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 communication was fragmented. AMHP practice then became a means of managing fragmented interprofessional working. AMHPs had a duty to respond to the requests for MHA assessments without a hospital bed having been identified, but recognised the irony of the practice situation: Tina, below, describes being habitually placed in foolish situations that jarred with her AMHP values:

> *So, the Responsible Clinician has seen them on a 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).*

Tina communicates her sense of frustration, when she indicates the inefficient use of her time, by using the term 'time wasting' when discussing her attempt to coordinate a Mental Health Act Assessment (MHAA) with a psychiatrist. Tina later stated she was left at the

psychiatrist's 'beck and call'. This feeling showed the dominant power Tina perceived the psychiatrist held over how she could practise as an AMHP.

In similar ways, the excerpt below, highlights how Diana was trying to negotiate for a bed to be made available from an unavailable bed management team whilst waiting at service user's house to take him/her to hospital:

> [I]*...goes to the person who manages bed management, if you can get hold of her...she's on holiday and all the other people were on holiday (Diana, Interview 3).*

The unavailability of the bed manager was the cause of significant delay to the patient, whose mental health presentation then deteriorated to the point of requiring police support until an inpatient bed was eventually found. 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), AMHPs acted as 'legal enforcers' (Leah, 2020) but were constrained by organisational policies. This finding is illustrated in the excerpt below:

> *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 were 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? 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! The thing is the bed suddenly became available in X, 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).*

In this example, the hospital that the patient was going to be admitted to was in an area with a high White British demographic, over 200 miles away from their home. This would have precluded visits from family members. The AMHP was also concerned that treatment in such an area may not have supported the patient's racialised identity or cultural needs. Ironies were illuminated by the lack of alternatives to hospital detention, as Tina could not implement a more appropriate treatment plan when an alternative bed was unavailable. This resource gap created tensions for Tina as she wanted a different outcome that would have

provided better support for the service user's recovery. This is consistent with the AMHP competency of 'being able to promote the rights, dignity and self-determination of service users consistent with their own needs and wishes to enable them to contribute to the decisions made affecting their quality of life and liberty' (4.4 AMHP competencies, HCPC, 2019).

AMHPs inhabited a 'twilight zone', located in places and spaces between a multitude of organisations, often stuck in the middle of interagency partnerships that had different (and often competing) priorities. Inevitably, as different organisations had different priorities, AMHPs were pressurised into adapting how they worked in order to meet other organisations' priorities, e.g., conveyance by police officers, would involve negotiation based on police perceptions of risk to others. Improvisation was key in how AMHPs navigated conflicting priorities, dealing with a high degree of both professional and personal risk:

> *Now they're* [police] *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 – it's 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).*

Elizabeth related the routine conflicts that occurred due to 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. AMHPs regularly stated that when attempting to convey a patient to hospital, they were advised by bed managers on how to carry out their role. This jars with the AMHP role to act as an autonomous and independent professional.

Tensions in multi-professional working and the AMHP's role

There were significant tensions inherent in the AMHP role, particularly between what AMHPs intended to achieve and the actual practice outcome. Rather than delivering quality care and treatment, AMHPs gave examples of how their role was diluted and how they were subjected to compromised positions that 'forced' them to make changes they disagreed with.

Diana below, discusses how her role was both diluted and constrained by the mental health system, illustrating an 'irony of adaptation'. Here she recognised, her own values were compromised, by a 'system' that was more powerful and influential than those AMHP values.

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

There were tensions between care and treatment provisions, arising from policy imperatives such as New Ways of Working (NIMHE, 2007) and the Five-Year Forward View (NHS England, 2014) and MHA Code of Practice (Department of Health, 2008) guidance which jarred with AMHPs' experiences of securing appropriate responses from other professionals, in this case the psychiatrist:

> *To me if they (psychiatrists) know them (the patient), 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 1).*

AMHPs engaged in negotiation that gave other professionals an impression of cooperation; it was a 'cloak of conformity' (Edgerton, 1993), so that participants could achieve the outcomes that were important to them, based on social perspectives that were informed by service users' best interests.

Constraints on practice were illustrated when AMHPs felt a disconnection between their values, their role definition, and the impact of scarce resources. 'Ironies of adaptation' were reflected in two forms of power; AMHPs' authority as a 'legal enforcer' of the decision to detain a patient , and their role as a *'*mediator*'* when they used their expertise and persuasion to pull together the resources for an inpatient admission (Leah, 2020). For example, Dawn, stated that she needed a code to obtain an inpatient bed. This involved Dawn obtaining a code that the bed manager had, however, she found that the bed manager

was not available, so the code could not be obtained. Consequently, she was unable to find a bed to admit the service user to hospital for several hours.

Ironies meant that AMHPs worked under conditions that did not make sense to them, which seemed foolish to follow, but which they had to follow, despite their disagreement with them. A 'fool's errand' was an inevitable outcome because the 'official' versions of the AMHP professional role as a legal applicant were predicated upon professionally related behaviour that was found to be inviable.

A 'fool's errand' was illuminated by the lack of alternatives to hospital detention, as participants could not implement alternative care and support plans when resources did not exist. Admissions that could be prevented were not being, due to the lack of community services (CQC, 2018). In summary, a 'fool's errand' (Willis, 2001) was a key feature of AMHP work, particularly with bed managers, police officers and ambulance crews when arranging conveyance, but also when psychiatrists left medical recommendations in places to be collected by AMHPs without holding a full mental health assessment in person.

Work based resistance and identities

Resistance via the 'cloak of conformity' takes the form of attempts to sustain recalcitrant professional identities. The illusion of conformity is constructed by emergent professional dynamics formed in interaction during MHAAs. Mental Health Act assessments therefore could be enacted via collusion as well as transgression of organisational norms and practices (Hughes, 2005). They were 'acts of resistance' positioned in such a way they could escape detection. Ironies meant that participants worked under conditions that did not make sense but which they had to follow, despite their disagreement with them. Findings of worker resistance in this study are largely informal, associated with irony and skepticism (Wright,

1978), and are to be distinguished from scholarly debate on traditional forms of worker resistance associated with Trade Unions (Edgell and Granter, 2020).

AMHPs' espoused identities featured claims for specialist knowledge, accentuating what was unique to their identity as a means of exercising their legitimate control over work areas. However, a difference between officially sanctioned practice and situated improvised practices was found in the study. AMHPs believed MHAA worked reasonably well, but services were inadequately resourced and interagency working was inefficient and problematic. Bonnet and Moran (2020) found AMHPs were suspicious of the Government's motivations for MHA reform and of its preoccupation with the MHA as a contributory factor for rising detention rates, rather than attributing the increase in detentions to the broader socio-political issues, e.g., poverty, racism, stigma, impacting on wider mental health services or the latent power dynamics between different mental health professionals.

Implications for practice

The final report of the Independent Review of the MHA considered recommendations to reduce inappropriate and prolonged detentions (Wesseley *et al*., 2018b), including raising the threshold for compulsory admission. However, despite 'introducing a new time limit by which a bed must be found following an order for detention' (Wesseley e*t al*., 2018b, p.118), no time limit is specified, and no consequence is given if the (as a yet to be specified) time limit is breached. Furthermore, there is no information regarding what additional resources are required to ensure beds are found in time to reduce patient suffering or to ensure professionals can respond proportionately to assessments, particularly given the phenomenon of AMHPs 'duplicating' MHAAs. Significantly, the review does not address the broader deterioration in social structures, nor the professional and structural issues, associated with reduced community resources, that could be used as alternatives to inpatient admission. Yet, AMHPs in this study strongly advocated for more beds to be made available, acknowledging that a lack of psychiatric beds has made it more likely for hospital

admissions to be delayed and for discharge to be accelerated, impacting detrimentally on patient recovery (Leah, 2020).

The unprecedented and unsustainable demand for mental health services, that was temporarily exacerbated by the impact of Covid-19 and the Corona Virus Act (2020) which made mental health detention possible on the recommendation of a single doctor, and the time limit for compulsory detention of individuals who would otherwise be in hospital voluntarily extended from 72 hours to 120 hours (Schedule 8) has left services stretched to breaking point, at a time when they are needed most. Investment in mental health is required urgently, ranging from preventative services to acute services to smooth the tensions involved in AMHP work, to 'make the wheels turn', and to provide improved service user experiences and better patient outcomes.

Limitations

There are individual differences and nuanced understandings in participants versions of themselves and their storied events of their AMHP work, that add value to an understanding of AMHP practice, yet cannot be generalised as participants may not have been representative of AMHPs and may have been influenced by gatekeeper bias (Hammersley and Atkinson, 2007).

Conclusion

AMHPs as public servants must to be able to respond in different ways to individuals depending on the issues presented during a MHAA. The situations they face are complex and cannot be reduced to prescriptive procedural responses. As 'street level bureaucrats' operating in situations of complexity and risk they make sense of legal requirements, policies, and procedures, and in applying them must interpret them (Leah, 2020; Lipsky, 1980). However, if AMHPs are subjected too much to other professionals interference and their misunderstanding of the MHA, this may needlessly result in contradictory, ambivalent

and unproductive working practices. Such practices can detrimentally impact on the quality of mental health support to service users and their carers experiences, leading to poor outcomes.

AMHPs are undergoing significant change in how their working practices and conditions are controlled; more and more they are faced with contradictions between policies and procedures and a role that is practised under increasing resource constraints (Leah, 2020). There are multiple chaotic, informal, and contradictory responses within AMHP practice. This is where the author has illustrated AMHP stories of their professional role containing examples of the 'fool's errand' (Willis, 2001; Hoyle and Wallace, 2007) borne out of the disjuncture between officially sanctioned practice and situated practices, that amplify subtle forms of worker resistance.

The article may have broader conceptual application to other public sector workers, nationally and internationally where professionals' practice differs from how professional work is perceived. Practice frameworks are often open to interpretation by those performing the role, and subject to informal guidance from employing organisations, and governmental departments. These findings are novel and add to existing literature on the sociology of professions, and AMHP practice, and are of contemporary relevance to the broader field of mental health practice.

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