Who wants to be an Approved Mental Health Professional?

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Social Care Workforce Research Unit

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About the Social Care Workforce Research Unit
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Project web page
https://www.kcl.ac.uk/sspp/policy-institute/scwru/res/roles/amhp.aspx

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**Summary**

**Implications of this research**
The shortage of Approved Mental Health Professionals (AMHPs) in England is a national concern in relation to the efficient running of mental health services and to the delivery of mental health care at times when it may most be needed. This research identifies changes that could help break down some of the barriers to the eligible health professionals taking on the AMHP role. Most fundamental, would be creating a joint responsibility for local authorities (LAs) and NHS Mental Health Trusts (MHTs) to run AMHP services. Short of sharing overall responsibility for the service, specific responsibilities to enable health professionals working for MHTs to take up AMHP training and ensuring that LAs agree to fund them (which may require extra funding for LAs) could also help. In addition, national decisions about the amount to pay AMHPs and how to pay them could help recruitment of AMHPs, as would an overall increase in the amount paid. Making the pay for AMHP work equivalent to the enhancements linked to becoming a nurse prescriber, for example, might start to create nurse career advancement linked to becoming an AMHP. Engagement with professional bodies, such as the Royal College of Nursing and Royal College of Occupational Therapists and regulators such as the Nursing & Midwifery Council, may also help to raise awareness of the role and again help foster greater confidence that becoming an AMHP is an important and rewarding means of career advancement for these health professionals. This report is timely in the context both of the 2018 review of mental health legislation in England (Department of Health and Social Care (DHSC), 2017) which will need, whatever its recommendations, to consider workforce capacity, and of the commitment made by the then Secretary of State for Health and Social Care to further integration (Hunt, 2018). Both changes will require attention to the workforce and can potentially learn from the creation and working of the AMHP role, with its aspirations to benefit from a wide variety of professional experience (see Vicary, 2016).

**Key research findings**
1. Most participants and survey respondents were positive about health professionals’ abilities to work effectively as AMHPs.
2. There are insufficient numbers of AMHPs, yet it is perceived to be difficult to recruit health professionals to the role.
3. Organisational contexts change, but these changes have no clear impact on AMHP recruitment.
4. Health professionals need to be highly motivated to become AMHPs, overcoming many hurdles.
5. The immediate and crisis resolution nature of AMHP work is attractive to many health professionals (as it is for social workers).
6. Organisational barriers, aspects of the AMHP role, and remuneration levels all discourage health professionals training and working as AMHPs.
7. Most participants consider that the most appropriate level of remuneration for AMHP work is in the NHS pay bands 6-7.
8. While some health professionals working as AMHPs reported receiving effective supervision, it was usually difficult to arrange.
9. Most of the health professional AMHPs experienced good support from colleagues, which was highly valued.
Findings

Context of AMHP services
Our survey found many recent or planned changes to mental health social work services in about half (n=16, 52%) of the areas where mental health services were controlled by Local Authorities (LAs). There were plans to re-integrate services (LA with NHS) in five areas where mental health services had been pulled back into LA control within the past three years, indicating substantial change in a short time. Several respondents commented that the statutory duties introduced by the Care Act 2014 (c. 23) had driven decisions to bring mental health social work teams back into LA control. However, this dynamic context appeared not to have a clear impact on the recruitment of health professional AMHPs. Unsurprisingly, enabling health professionals to become AMHPs was thought by a large majority (over three quarters) of survey respondents it be ‘Very difficult’ or ‘Difficult’. A large majority of survey respondents reported very high percentages of AMHPs were social workers and almost two thirds (n=31, 63%) said that all their AMHPs were social workers. Unions and professional bodies appeared to have very little role in promoting the AMHP role to health professionals. In the survey, at least three quarters of AMHP Leads (senior managers responsible for and leading on AMHP services) reported that AMHP training was available to all the health professionals willing and able to take up the role. However, there appeared to be little backfill (replacement of their time) available for them to take up the courses.

Health professionals’ motivations to become AMHPs
Health professionals needed a high degree of motivation to become AMHPs, often having to overcome opposition from their managers. Four ways of increasing take-up of the AMHP role by health professionals were identified:

• Raising awareness of the possibility of health professionals becoming AMHPs.
• Improving the reputation of the AMHP role.
• Higher remuneration and career prospects.
• Good management arrangements.

Factors preventing or discouraging health professionals from becoming AMHPs
Three broad themes were identified: organisational; aspects of the AMHP role; and remuneration.

Organisational
Some managers of integrated teams found it hard to allow health professionals time away from caseload work to take part in the AMHP rota. Separate LA and MHT social work teams were also seen by some to create difficulties in managing the AMHP work when undertaken by health professionals. In addition, some health professional AMHPs experienced difficulties fitting into a social care team on an intermittent basis.

Aspects of the AMHP role
AMHP work was characterised by some as a ‘rite of passage’ for social workers, which was felt to be in sharp contrast to the experience of health professionals, who tended not to see becoming an AMHP as advantageous for career progression. A commonly expressed view was that AMHP work might damage therapeutic relationships, which were seen to be at the heart of nurses’ and psychologists’ (in particular) roles, although some dismissed this as a ‘myth’. In a similar vein, many identified a clash of values between the ethos of the health professions and AMHP work. Furthermore, some had experienced an ‘anti-health’ prejudice amongst trainers and managers. The general impressions of AMHP work as stressful and involving long working hours were also identified as discouraging some health professionals.

Remuneration factors
Several aspects related to remuneration could also discourage health professionals. First was a perceived inconsistency of financial rewards across the country, a factor that affects recruitment of AMHPs from any profession. Some were not happy with a flat addition to salary that did not take account of how much time was spent on the rota or the numbers of Mental Health Act (MHA) assessments completed. In addition, concerns were expressed about disparities between NHS pay bands and the LA salary grades, which could mean that social worker and health professional AMHPs were being paid at different levels.
Working as an AMHP
While remuneration was rarely expressed as a direct motivation, it was still an important factor for interview participants and survey respondents. Most professional participants identified NHS Band 6 or Band 7 (or somewhere in between) as being the most appropriate pay level for AMHP work, with Band 7 being mentioned most often. Many participants believed that health professionals had the knowledge and skills needed to work as AMHPs and that they were in the main able to challenge psychiatrists, a key part of the AMHP role. As with social workers, health professionals appeared to enjoy the crisis resolution element of the work, and the sense of immediate (ultimately positive) impact on individuals.

While many AMHPs reported receiving good supervision, arranging supervision was complex where AMHPs worked mainly in health teams and undertook shifts on the AMHP rota in LA-based teams. As with many aspects of work in this area, good support from colleagues was identified as critical, and, in the main, AMHPs reported positive experiences.

Views about health professional AMHPs
Several advantages and disadvantages to health professionals working as AMHPs were identified.

Advantages
• A wider range of experience and perspectives is brought to the role (e.g. knowledge of physical health)
• The role and service as a whole are open to different kinds of intervention and models
• Health qualified AMHPs improve practice within health teams
• The AMHP service has greater ability to allocate the right professional (either because of profession or personal qualities) to the assessment and other tasks
• A broad range of professionals encourages different agencies to be more engaged with the AMHP service
• Health qualified AMHPs may have substantial prior experience of crisis work
Methods

The study involved four strands:

1. A survey of Local Authority AMHP Leads (n=51), who are responsible for the AMHP service in the local authority
2. Interviews with the health professionals who are warranted to work as AMHPs (n=12) and those who have not chosen to take up this opportunity (n=18)
3. Interviews with people with mental health problems and their families, who have had direct experience of Mental Health Act assessments by AMHPs (n=7)
4. Interviews with professionals (police, psychiatrists, managers, commissioners, regulators) working alongside AMHPs in or with mental health and associated services.

In all, 57 semi-structured interviews were undertaken with the different groups, as set out in Table 1:

<table>
<thead>
<tr>
<th>Participant role</th>
<th>AMHPs</th>
<th>Non-AMHPs</th>
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<td>AMHP Leads</td>
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Disadvantages

- Health professionals may find it difficult to adopt a social perspective
- Social workers sometimes see the AMHP role as a social work role and object to other professionals taking it on
- Variations in qualifying training may lead to inconsistency of AMHP practice
- The role creates generalist practitioners rather than specialists

About the study

Background and aim of the research

Over ten years after the Mental Health Act 2007 enabled mental health and learning disability nurses, occupational therapists and psychologists to work as Approved Mental Health Professionals (AMHPs) (with legal powers of assessment for possible compulsory detention or treatment) only 5% of AMHPs are not social workers (Carson, 2018). This is in the context of both a shortage of AMHPs and increasing numbers of Mental Health Act (MHA) assessments, which are one of the main functions of the AMHP (Hudson and Webber, 2012; NHS Digital, 2016; Perkins and Repper, 2017).

These points underpinned the need for this research, which aimed to identify factors encouraging and discouraging the recruitment of mental health and learning disability nurses, chartered psychologists and occupational therapists (OTs) as AMHPs.
1 | Introduction

This research was commissioned by the Department of Health and Social Care in order to inform its continued responses to the Mental Health Crisis Care Concordat (HMG, 2014) recommendations about developing Approved Mental Health Professional (AMHP) services. In addition, the research was required to inform the development of a national framework for AMHP training by the new regulatory agency for social work (Social Work England). The aim was to identify barriers and explore factors encouraging health professionals taking up the AMHP role. This report is timely in the context both of the 2018 review of mental health legislation in England (Department of Health and Social Care (DHSC) 2017), which will need, whatever its recommendations, to consider workforce capacity, and of the commitment made by the then Secretary of State for Health and Social Care to further integration (Hunt, 2018).

The study is one of several that are setting the scene for the proposed reforms of mental health law in England and political commitments to further integration of health and social care.

1.1 Background
The Mental Health Act 1983 (MHA) as amended by the Mental Health Act 2007 made it possible for non-medical health professionals, namely chartered psychologists, mental health and learning disability nurses and registered occupational therapists, in addition to social workers, to become Approved Mental Health Professionals (AMHPs), replacing the Approved Social Worker (ASW) role, with very similar responsibilities (Gregor, 2010). While AMHPs operated in a similar way in Wales, it is important to remember that secondary NHS mental health care is provided by local health boards (and not NHS Trusts), and that the MHA and the work of AMHPs takes place against the background of Wales-only legislation, including the Mental Health (Wales) Measure 2010. The role in Wales is broadly similar: local authorities are responsible for providing the service and the same professionals are able to train as AMHPs (Welsh Government, 2008).

AMHPs coordinate MHA assessments; typically, this involves inviting and liaising with two medical clinicians and arranging for the assessment to take place. If the outcome of the assessment is a compulsary or voluntary admission to hospital, AMHPs have to find a hospital bed, organise an ambulance to transport the patient and accompany them to hospital. Crucially, as set out in the Department of Health (DH) Code of Practice for the Mental Health Act 1983, updated in 2015:

*The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principle.*

(DH, 2015: 122)

There is no single definition of what is meant by a 'social perspective' in the Mental Health Act 1983 Code of Practice (DH, 2015). The idea of a social perspective can be traced back to the beginnings of NHS psychiatry, and the recognition of the importance of social aftercare (Coffey and Harrigan, 2013). Tew (2004) acknowledged that there is no one definition of a social perspective but identified a number of key elements:

1. Ending the distinction between 'normal' people and those suffering mental distress
2. Taking a holistic approach, seeing people within their social contexts (socio-economic status, demographic characteristics and family circumstances)
3. A commitment to listen and to take full account of what people say about their mental distress, suggesting a move away from a medical model, which focuses on symptoms
4. A focus on 'principles of anti-oppressive and
empowering practice’ (p17), highlighting power relationships and an awareness of ‘factors which may diminish people’s sense of self-esteem or constrain their personal, social or economic opportunities’ (Tew, 2004 p16-17).

This indicates the need for AMHPs to be able to act independently, particularly of clinicians’ advice and also to identify and assess the relevant circumstances and explore alternatives to detention. In addition, AMHPs must liaise with the ‘nearest relative’, usually a close family member, who has a number of rights under the MHA, for example, the right to request a MHA assessment (National Institute for Mental Health England (NIMHE), 2008).

The AMHP role was given some new responsibilities compared with the previous ASW role. For example, AMHPs, along with all mental health professionals, are required to involve Independent Mental Health Advocates (IMHAs) for patients, if they request this. IMHAs can meet with patients, consult with professionals and access records (with consent from the patient) (Social Care Institute for Excellence (SCIE), 2014). AMHPs also have to decide whether a Community Treatment Order is appropriate. These Orders, also introduced by the Mental Health Act 2007, can be made in relation to patients who have been discharged after detention in hospital under the MHA 1983 (DH, 2015). An Order structures treatment and can include compulsory treatment on being returned to hospital. In all these new roles, the importance of adopting a social perspective is emphasised.

Vicary (2016) notes that the creation of the AMHP role was part of a broader policy focus on multi-disciplinary working and organisational integration, in addition to a desire to benefit from a wide variety of professional experience. Despite evidence (Vicary, 2016) that health professionals can perform the role successfully, only 5% of AMHPs are not social workers, according to the findings of a Freedom of Information request for such details undertaken by Community Care (Carson, 2018). Coffey and Hannigan (2013) argue that financial considerations in local authorities and NHS trusts may have discouraged these organisations from investing in training health professionals to become AMHPs and supporting them in the role. Indeed, local authorities hold the training funds for AMHPs and are thought by some to give preference to their employees (personal communication with NHS MH Social Work Lead, March 2016). Furthermore, problems in relation to disparity of pay for nurses and social workers have also been thought to discourage nurses in particular from applying (Jackson, 2009); other alternatives for them, such as prescribing skills’ qualifications, are more remunerative, for example (personal communication NHS Social Worker, March 2016).

A survey of AMHPs undertaken in 2012 found that over a fifth of the sample survey wanted to stop being an AMHP and almost another fifth was unsure about whether they wanted to continue in the role (Hudson and Webber, 2012) (this was not followed up, so we do not know if they continued or not). This survey also found very high levels of stress amongst AMHPs, with over two fifths (43%) reaching the threshold for common disorders of depression or anxiety. The DH and Care Quality Commission ((CQC), 2016) review of AMHP monitoring acknowledged a shortage of AMHPs.

At the same time, there are increasing numbers of detentions under the MHA, all of which require AMHP involvement (NHS Digital, 2016). This was one of the concerns behind the 2018 Mental Health Act Review. The increase in detentions has been argued to be linked to a national shortage of mental health hospital beds and cuts to community mental health services (Perkins and Repper, 2017), which exacerbates the impact of bed shortages, by increasing occupancy.

Despite the option to recruit health professionals as AMHPs, local authorities continue to hold responsibility to run and manage AMHP duties, which cannot be delegated to the NHS. Consequently, local authorities:

• support and train AMHPs
• ensure competency
• provide indemnity
• provide legal advice in relation to AMHPs’ duties

(DH and CQC, 2016: 6)

This may add complexities to the recruitment and management of AMHPs from health professions (Coffey and Hannigan, 2013). While this may also apply in Wales, it is important to note that
secondary mental health services are provided by Local Health Boards, which plan, secure and deliver health services, rather than NHS Trusts, which provide these services in England. It is possible that a different approach might be taken in relation to releasing nurses and OTs to become and work as AMHPs, by Local Health Boards, which have a broader focus. In this context, the evidence about an increased demand for AMHPs at a time when there are smaller numbers working in this role supported the need for this research summarising and exploring factors inhibiting recruitment and retention of health and allied professional AMHPs.

Social workers have been found to be motivated by the time-limited and ‘contained’ nature of AMHP work; by the expectation from managers that they would train as an AMHP; perceptions of increased job security and increased status associated with the role (Gregor, 2010; Morriss, 2016; Watson, 2016). However, the emotional labour and potential impact of the decisions about detention involved in AMHP work, were seen by participants in Watson’s (2016) research as being both a motivating factor and a challenge. Watson’s (2016) study also identified a further motivation as the ability to employ a social perspective on mental health to challenge the medical model. In an earlier study, ASWs felt that they were often well placed to undertake the work as ‘a very human face with quite a bit of statutory power’ (Gregor, 2010: 435), and were able to identify and advocate for the least restrictive option. Given the stressful nature of the work, Gregor (2010) and Morriss (2016) argued that good support is essential to retain AMHPs, which may be particularly difficult for social workers seconded to and health professionals working in mental health trusts.

Many of the factors involved in motivating and retaining AMHPs identified in the studies of social work motivations may apply to recruiting and retaining nurses, psychologists and OTs as AMHPs, but other factors need to be considered for these professionals. While social workers are trained to operate within a social perspective, this may be more challenging for nurses and the other professionals but is required in order to undertake the work (Coffey and Hannigan, 2013). Mental health and learning disability nurses need to develop a therapeutic relationship with patients, which can ‘engender trust, honesty and collaborative decision-making’ (Coffey and Hannigan, 2013 p1424): such relationships could be damaged by nurses implementing the coercive element of the AMHP role. In addition, Coffey and Hannigan (2013) argue that the close alliance between nursing and psychiatry has meant that nurses are expected to undertake more biomedical roles, in relation to medication and physical health, and that this may also make it more difficult to adopt a social perspective. It may also make it more difficult for nurses to challenge psychiatrists' opinions. They also argue that claims that nurses can adopt a bio-psycho-social approach are limited by what they view as the dominance of the biomedical approach. In contrast, Vicary (2016), who interviewed non-social work AMHPs, concluded that health professionals could hold both perspectives in their approach to MHA assessments.

Three factors discussed above support the need for research exploring the motivations and factors that may discourage mental health and learning disability nurses, chartered psychologists and occupational therapists (OTs) from becoming AMHPs at individual, team, employer and cultural or system levels. First is the apparent shortage of AMHPs in a context of increased demand for their services. Second is the predominance of social workers working in the role. Third is the fact that almost all of the empirical evidence reflects the motivations and experiences of social workers working as AMHPs. Role tensions with professional values and organisational contexts will be important aspects to explore, as will the attractions of the levels of discretion and status involved. There is a further question about the differences in practice at team and organisational levels of having a broader AMHP disciplinary base – and the implications of any such differences for the support of people with mental health problems and their families and other services.
1.2 Research aim
The overall aim of the research was to identify factors encouraging and discouraging the recruitment of mental health and learning disability nurses, chartered psychologists and occupational therapists as AMHPs.

1.3 Research questions
1. What are the motivations of health professionals (nurses, psychologists and OTs) to become AMHPs?
2. What prevents health professionals from becoming AMHPs?
3. What are the experiences of health professionals of working as an AMHP?
4. What management and colleague support is there for AMHPs in NHS Trusts and Local Authorities?
5. What policies and plans do local authorities have that aim to increase recruitment and improve retention of AMHPs from all professional groups?
6. What are the views of patients/service users and families about mental health and learning disability nurses, psychologists and OTs being AMHPs?
7. What are the views of mental health colleagues (e.g. police, psychiatrists, managers, commissioners, regulators) about mental health and learning disability nurses, psychologists and OTs being AMHPs?
2 | Methods

A multi-method approach was adopted to explore different perspectives on the recruitment and retention of AMHPs. Four separate strands of the research were undertaken

- Interviews with nurses, chartered psychologists, and OTs (Research questions 1-4)
- Interviews with managers of AMHP services
- A survey of Local Authorities (Research question 5)
- Interviews with people with mental health problems and their families (Research question 6)
- Interviews with professionals (police, psychiatrists, managers, commissioners, regulators) working with mental health and associated services (Research question 7)

2.1 Sampling
The aim of the sampling approach was to achieve maximum variation rather than a representative sample. We used a mixture of purposive, convenience and snowballing approaches. To ensure responses from people who met our criteria, we sent information about the study to relevant networks and used our contacts to identify individuals from different groups of interest. This is one element of purposive sampling and ensured that participants had views and experiences relevant to the research problem, while ameliorating one risk of convenience sampling (Etikan et al., 2016). We contributed a blog to Community Care (Martineau, 2017), which explained the need for the research and called for volunteers for the semi-structured interviews and survey. However, participants were self-selected (reflecting the convenience element), which may have meant that they had particularly strong views or vivid experiences, which may have influenced the research findings.

However, as Robinson (2014) notes, all interview-based research involves self-selection to the extent that participation is voluntary and researchers can only reflect on this possibility in writing up their research. We have reflected on this in the discussion chapter.

2.2 Recruitment of interview participants

2.2.1 AMHP leads and other professionals
National networks, such as the National AMHP Leads Network, Mental health and learning disability nurses Association; two Twitter groups (@WeMHNurses and @WeLDNurses); the Clinical Psychology division of the British Psychological Society and the Royal College of Occupational Therapists supported recruitment of participants. These organisations and networks distributed information about the research: potential participants contacted us if they were interested in taking part. In addition, we approached personal contacts and asked if they would be interested in participating in the research.

2.2.2 People with mental health problems
Local groups of mental health service users (such as the National Service User Network; Shaping our Lives; McPin Foundation) were contacted and they were asked to facilitate contact with people (or family members) with experience of MHA assessments by AMHPs. We asked these groups to send out information to their members; advertise it in any centres, invite us to attend groups or centres to introduce the research and distribute information sheets. Individuals showing an interest were asked for their contact details and for permission to contact them to discuss the research further.

2.2.3 Informed consent
All potential interview participants were given an information sheet, which explained what the research was about, what taking part involved; why we contacted them and an explanation about confidentiality and data security. We contacted them again at least a week later (or two weeks if
they did not respond to the initial email) to answer any questions they may have and asked if they would be willing to take part in the research. Written consent was taken on the day of the interview. We included an information sheet with the online survey, which explained that submission of the questionnaire represents consent to take part.

2.3 Semi-structured Interviews

Semi-structured interviews were used as a means to explore issues relating to a specific topic. Topic guides were developed using insights from previous studies on social work AMHPs, such as Gregor (2010), and with input from the project advisory group.

In total, 56 semi-structured interviews were undertaken with different groups, as set out in Table 2.1.

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<th>Non-AMHP</th>
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2.3.2 Interviews with nurses, chartered psychologists, and OTs (Research questions 1-4)

Semi-structured interviews were undertaken with 12 AMHPs, namely six Registered Mental Health Nurses (RNMs) and six Occupational Therapists (OTs). Such a sample is similar to that of Vicary’s study (2016) but in addition we also interviewed 18 health professionals who were not AMHPs: namely five RNMs and one Registered Learning Disability Nurse (RNLD); six OTs; and six psychologists. It is reported (Carson, 2018) that only one psychologist has become an AMHP, and we were unable to recruit him or her. Following Gregor (2010), interviews with professional AMHPs covered:

- What motivated you to train as an AMHP?
- What keeps you motivated to work as an AMHP?
- Do you receive supervision as an AMHP (and what form/frequency)?
- Do you feel valued and supported by professional colleagues, other colleagues, and management? (evidence of this)
- How do you describe what your role as an AMHP?
- Are there any conflicts in your role?
- What, if anything, do you find difficult about AMHP practice?
- What, if anything, are the most important aspects of the AMHP task?
- What, if anything, do you think hinders good AMHP practice?
- What are your views on AMHP training being open to other professionals?

In addition, the interviews covered:

- The balance of AMHP and other work
- External factors affecting experience of the work
- Relationships with other mental health professionals and other staff

Interviews with health professionals who are not AMHPs covered:

- Whether they had decided not to become an AMHP and why
- Relationships with AMHPs
- Views of the most important aspects of the AMHP task
- Views on what might hinder good AMHP practice
- Views on AMHP training being open to other professionals

Nine interviews with AMHP Leads were undertaken, covering:

- Organisation of mental health /adult services and how this affects management and support of AMHPs; any work pressure relevant to the AMHP role
2.4 Survey of Local Authority AMHP Leads (Research question 5)

AMHP Leads manage AMHP services within a local authority, and are therefore best placed to provide an overview, which was the aim of the survey. A short online survey was developed, in collaboration with the project advisory group and with particular input from Steve Chamberlain, who chairs the AMHP Leads Network. The survey was distributed using the Bristol Online Survey tool. It was distributed through the AMHP Leads Network, sent to all Directors of Adult Social Services, the Principal Social Workers Network and the Chief Social Worker for Adults to pass on to AMHP leads within their LAs. The survey covered:

- Organisation and allocation of AMHP work
- Supply of AMHPs
- Experience of recruiting and training AMHPs and plans for the future
- Current policies or plans to improve retention of AMHPs.

2.4.1 Response

Despite repeated reminders, and publicity through Twitter, only 53 completed surveys were returned. Two participants indicated they worked outside of England. Given the specific policy focus of the research, it was decided to exclude these two responses from the analysis. Of the valid 51 survey responses, almost all (n=47, 94%) were from AMHP Leads, managers with immediate line management responsibility for AMHPs and the AMHP service (n=37, 74%) or senior managers (n=10, 20%), with a wider range of responsibilities, including the AMHP service, as shown in Table 2.2. Three responses were from AMHPs. While we intended to reach AMHP Leads, we have reported findings from all of these respondents. One respondent did not provide details of their role.

<table>
<thead>
<tr>
<th>Respondents' role</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMHP Lead</td>
<td>37</td>
<td>74</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>AMHP</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Most, two thirds (n=34, 67%), respondents were from areas where mental health teams were
managed within the local authority; the other third (n=17, 33%) were AMHP Leads where mental health services were integrated with the NHS. Most of the integration arrangements were long standing, with only three being less than 3 years old. There appeared to be a fair amount of change planned or recently implemented in organisational responsibility for mental health services. One fifth (n=10, 20%) of respondents reported that mental health social work teams had returned to local authority (LA) control within the last three years. Just over a fifth (n=11, 22%) reported plans to integrate mental health social work teams with NHS services. Five respondents said that mental health social work teams had returned to local authority control in the last three years but that there were plans to integrate mental health social work and NHS services.

2.5 Data analysis

2.5.1 Semi-structured interviews

Thematic analysis was used, as the most appropriate approach to analysing these semi-structured interviews and free text comments in the survey. This approach is fundamental to many kinds of qualitative research (Braun and Clarke, 2008). In addition, some matrix analysis techniques (Miles and Huberman, 1994) were used to compare and contrast the categories relating to processes and meanings and to identify different perspectives.

Most interviews were conducted on the telephone (n=47) and all interviews were recorded, with permission, and transcribed in full. The transcripts were entered into NVivo software and coded using coding frames, which were based on the interview guides, but evolved as coding progressed. We originally intended to develop coding frames through initial reading of transcripts. However, the interview guides were fairly tightly structured, and it was decided to use these as initial coding frames and add to them as coding continued. All members of the research team coded interviews they undertook. New sub-codes emerging were discussed within the team on a regular basis.

Coding is a key element of the approach to analysis, in order to interpret and organise the data (Basit, 2003). An initial coding frame was developed from the interview guides and then members of the research team read transcripts from each professional to develop the coding frame. The coding frame was also informed by the literature review, so that coding was sensitised to subtle differences in the data (Braun and Clarke, 2008).

The next step involved reading the coded text and the perspectives of professionals with different roles and people with mental health problems or family members were explored separately. Any links between codes were identified, then broader codes and categories developed and used to structure the factors encouraging or discouraging recruitment and retention of AMHPs from the different perspectives. The relative importance of different themes and ideas was assessed by:

1. how often it appears, 2. how pervasive it is across different types of cultural ideas and practices, 3. how people react when the theme is violated, and 4. the degree to which the number, force, and variety of a theme’s expression is controlled by specific contexts (Opler, 1945: cited by Ryan and Bernard, 2003 p87).

These are the general descriptions of the approaches taken to analysing the qualitative data. It is important to note that qualitative analysis is always flexible and that new ideas and directions often appear during the process (Miles and Huberman, 1994).

2.5.2 Survey

Quantitative data from the survey were downloaded into SPSS quantitative analysis software. Simple descriptive approaches were used to explore the data. Missing data are reported in the Tables, and percentages are used, to indicate the relative strength. No inferential statistics were used.

2.6 Research ethics and governance

Ethics approval was obtained from the Health Research Authority Camberwell St Giles Research Ethics Committee, which was required because we wished to interview people with mental health problems. We did not need to obtain Health Research Authority approval more generally because we intended to recruit other participants through non-NHS networks.

All participants were provided with information about the research, which stressed the voluntary nature of participation and included clear
statements about the confidentiality of the information given. We made it clear that we would not pass on information given unless a participant disclosed that someone is or is at risk of being harmed.

### 2.7 Advisory group

We recruited an advisory group consisting of members of the different eligible health professions, other experts in mental health policy and practice, and people with experience of mental health problems and families. This group met twice in the project. Once at an early stage, to help plan the project, comment on the overall approach, contribute to the design of interview guides and the survey and advise us on the best way to recruit participants. At the second meeting, near the end of the study, the group discussed emerging findings and helped develop some policy options arising from the research.
3 | Context of AMHP services

3.1 Organisational change
The organisational context for mental health social work has undergone substantial changes over the past decades. There had been increasing integration of mental health social work and health teams, with many being managed through NHS Trusts under section 75 (NHS Act 2006) agreements. As we noted in the Methods section, in 2017 mental health social work services were managed by LAs in two thirds (n=34, 67%) of areas responding to our survey and managed by NHS Trusts in the other third (n=17, 33%). There was evidence of much recent or planned changes to mental health social work services in about half (n=16, 52%) of the areas where those services were controlled by LAs. As Table 3.1 shows, there were plans to re-integrate services in five areas where mental health services had been pulled back into LA control within the past three years, indicating a great deal of change in a short time. Integration of mental health services was planned in a further six areas, making 11 (35%) overall, and mental health services had been pulled back into LA control in five other authorities, making 10 (32%) in total.

In interviews, AMHP Leads reported plans to return MH social work teams in three (of 17) areas where MH social work teams were integrated with health teams, although two did not know whether there were any such plans.

Several respondents commented that the statutory duties introduced by the Care Act 2014 (c. 23) had driven decisions to bring mental health social work teams back into LA control. Others also felt that such decisions had ensured that professional social work identity and service were maintained:

The change was brought about for two reasons, broadly speaking; firstly, concerns about professional SW [Social Work] practice, leadership and governance being able to maintain presence and authority within the trust; and secondly, we had been unable to implement the Care Act as required within Trust structures.

Survey 36

<table>
<thead>
<tr>
<th>Plans to integrate mental health social work and health services</th>
<th>Whether MH SW returned to LA control in the last three years?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
<td>No (%)</td>
</tr>
<tr>
<td>Yes</td>
<td>5 (50)</td>
<td>6 (29)</td>
</tr>
<tr>
<td>No</td>
<td>4 (40)</td>
<td>9 (43)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (10)</td>
<td>6 (29)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10 (100)</strong></td>
<td><strong>21 (100)</strong></td>
</tr>
</tbody>
</table>

* Questions answered by AMHP Leads in LAs; missing = 3
Given the LA responsibility for the AMHP service, it might have been expected that these organisational changes would have relevance for recruiting and supporting AMHPs. However, survey findings suggest a mixed picture, with at least half of all AMHP Leads in areas where the LA controlled mental health social work services feeling these changes had made no difference to recruitment of AMHPs. Table 3.2 shows that about a third (n=8, 33%) of survey respondents felt that pulling mental health social work services back into LA control had made it more difficult to recruit AMHPs although one sixth (n=4, 17%) felt the change had made recruitment easier. Plans to integrate mental health social work services were mostly (n=20, 77%) considered to make no difference, with equal numbers (n=3, 12%) reporting that the plans would make recruitment easier or more difficult.

<table>
<thead>
<tr>
<th>MH Social work teams returned to LA control within the last 3 years (%)</th>
<th>Plans to integrate MH Social work teams with NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made it easier to recruit</td>
<td>4 (17)</td>
</tr>
<tr>
<td>Made no difference</td>
<td>12 (50)</td>
</tr>
<tr>
<td>Made it more difficult to recruit</td>
<td>8 (33)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (100)</td>
</tr>
</tbody>
</table>

Missing = 1

Reasons given by AMHP Leads for making it easier to recruit, after integration, were that there was better opportunity to focus on AMHP training and retention and an increase of potential candidates as more professionals beside social workers were aware of the role. But others said that it had become more difficult as the importance of mental health work had decreased. Others commented that it made no difference to their service because AMHPs needed to be social workers due to them being required to meet other responsibilities under the Care Act.

### 3.2 Enabling health professionals to become AMHPs

Unsurprisingly, enabling health professionals (RNMH/RNLD, psychologists or OTs) to become AMHPs was thought by a large majority (over three quarters) of survey respondents to be either ‘Very difficult’ (n=21, 43%, n=36, 75% and n=22, 48% respectively) or ‘Difficult’ (n=17, 35%, n=9, 19% and n=19, 38% respectively), as shown in Table 3.3. Whether mental health services were managed by LAs or mental health NHS trusts was not associated with respondents’ views about how easy or difficult it is to enable health professionals to become AMHPs (RNMH/RNLDs (χ²=2.308, p=0.511), psychologists (χ²=2.101, p>0.350) or OT AMHPs (χ²= 6.098, p>0.107)).

<table>
<thead>
<tr>
<th>How Easy or difficult</th>
<th>RNMH or LD Nurse AMHPs (%)</th>
<th>OT AMHPs (%)</th>
<th>Psychologists (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>1 (2)</td>
<td>1 (2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Easy</td>
<td>10 (20)</td>
<td>6 (13)</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Difficult</td>
<td>17 (35)</td>
<td>19 (40)</td>
<td>9 (19)</td>
</tr>
<tr>
<td>Very Difficult</td>
<td>21 (43)</td>
<td>22 (48)</td>
<td>36 (75)</td>
</tr>
<tr>
<td>Total</td>
<td>49 (100)</td>
<td>48 (100)</td>
<td>48 (100)</td>
</tr>
</tbody>
</table>

Missing = 1

Those that said that it was ‘very easy’ or ‘easy’ for health professionals to become AMHPs commented that technically all professionals specified in the 2008 regulations (National Institute of Mental Health England, 2008) could train (or be recruited) to become AMHPs. Several respondents added that they had changed local job descriptions to include other professional backgrounds besides social workers. Others said that they actively supported health professionals to become AMHPs. There was also agreement that it was easier for RNMHs or RNLDs to become AMHPs, compared with OTs and psychologists.

A majority of those saying that it was ‘very difficult’ or ‘difficult’ to enable health professionals to become AMHPs commented that staff members with these backgrounds had limited access to training (see below for more details) and were often not released or seconded to work in this role.
Integration in the service rota system was also perceived as a barrier to health professionals being AMHPs, especially if qualified AMHPs were employed by organisations other than the LA. Others felt that health professionals had not enough knowledge about the role or the possible career path. It was also said that the AMHP role was often fulfilled in addition to other responsibilities:

_Each discipline is busy and perhaps the additional role of AMHP is perceived as adding too much stress to their already stressful workload and justifiably so._

Survey 26

As might be expected, most respondents reported very high percentages of their AMHPs were social workers. Almost two thirds (n=31, 63%) said that all their AMHPs were social workers and a large majority (n=42, 85%) that over 90% of their AMHPs were social workers. Over half (n=22, 54%) reported employing no mental health or learning disability nurse AMHPs. While five (10%) respondents said that over 10% of their AMHPs were mental health or learning disability nurses, all of these were in authorities with small numbers of AMHPs overall (9-11). Nearly nine out of ten (n=37, 87%) participants reported they employed no OT AMHPs, and very low numbers were reported overall. None of the participants reported employing any psychologists as AMHPs. One respondent offered an explanation that echoed others’ views:

_One of the primary reasons Social Workers take up AMHP training is because it represents career progression and is seen as such with the LA - both the status in the team structures and salary support this. For health staff, it doesn't improve their career opportunities and their employers don't offer any salary supplement for undertaking this role. It's a whole load more responsibility for little return - these staff watch AMHPs struggle day to day with diminishing resources, so it should be clear why they aren’t attracted._

Survey 02

3.3 Training

Access to training is central to enabling professionals to become AMHPs, as was identified in the survey and the interviews. Almost all (n=47, 92%) survey respondents observed that the LA funds AMHP training and a further two were funded by mental health partnerships. In only one case did the AMHP Lead indicate that the mental health trust funded training and in another it depended on which organisation employed the staff member applying to train as an AMHP.

At least three quarters of AMHP Leads surveyed reported (as shown in Table 3.4) that AMHP training was available to RNMHs and RNLDs (n=40, 78%); OTs (n=37, 74%); and psychologists (n=33, 79%), although nine respondents did not answer the question about psychologists.

<table>
<thead>
<tr>
<th>Whether training available</th>
<th>RNMH/RNLD</th>
<th>OTs</th>
<th>Psychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>40 (78)</td>
<td>37  (74)</td>
<td>33  (79)</td>
</tr>
<tr>
<td>No</td>
<td>7  (14)</td>
<td>8   (16)</td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td>4  (8)</td>
<td>5   (10)</td>
<td>9   (21)</td>
</tr>
<tr>
<td>Total</td>
<td>51 (100)</td>
<td>50  (100)</td>
<td>42  (100)</td>
</tr>
</tbody>
</table>

In some LAs, before health professionals are allowed to undertake AMHP training they have to go through an application process to evidence experience or complete pre-requisite training (as required for some social workers). The majority of those reporting that such training was available to health professionals said that they were either not approached by other organisations for their staff members to undertake AMHP training (despite it being advertised in NHS Trusts) or because staff members were not released from their roles within the Trust to do the training:

_The training is available to all; however, this is not taken up by staff within the trust in our area due to on-going difficulties between the trust and local authority._

Survey 28

This fits with one of the strongest themes emerging from the interviews, that a particularly strong motivation was required for health professionals to become AMHPs.
Besides not being released, reasons given why health professionals were not able to attend training in some areas were that the LA only allowed LA-employed staff to undertake AMHP training, that no additional funding was available or because of a lack of agreement about how to support Trust staff to undertake AMHP training:

**The Trust and local authority have no agreement about how Trust staff could be supported to do the training and what the management and contractual arrangements would look like if they did.**

Survey 12

Regarding the individual health professions, respondents said that no chartered psychologist had expressed interest in AMHP training. However, one psychologist interviewed had indicated a willingness to train as an AMHP, if the training would focus solely on the knowledge and skills needed for AMHP work, but not involve a general social work qualification, and that their psychology qualifications would be accredited, reducing the need for further training:

**Because like I said, nurses study three years, psychologists usually study three years more, up to five years, but the difference with social workers is they do four years I think. Why do the psychologists have to do all this extra? It's a bit tiring, that's why maybe you'll see psychologists working in completely different things. At least if there is a fast-track, which I believe that there is for an AMHP, I will do.**

PSY Non-AMHP 03

A lack of awareness and information about the training being available to eligible professionals was also mentioned:

**Because the AMHPs sit with the local authorities, mental health professionals other than social workers have little information about the training and how to access this career path.**

Survey 01

While most AMHP Leads said that courses were open to health professionals, there appeared to be little backfill available for them to take up the courses: Table 3.5 shows that about two-fifths of respondents reported backfill was not available for any of the professional groups and at least two fifths did not know. Only three AMHP Leads indicated that full backfill was available for nurses, two for OTs and one for psychologists.

**Table 3.5: What backfill is available to support health professionals take up AMHP training?**

<table>
<thead>
<tr>
<th>Amount of backfill</th>
<th>RNMH/RNLD</th>
<th>OTs</th>
<th>Psychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>3 (6)</td>
<td>2 (4)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Partial</td>
<td>2 (4)</td>
<td>2 (4)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>None</td>
<td>21 (45)</td>
<td>19 (41)</td>
<td>17 (39)</td>
</tr>
<tr>
<td>Don't know</td>
<td>21 (45)</td>
<td>23 (50)</td>
<td>25 (57)</td>
</tr>
<tr>
<td>Total</td>
<td>47 (100)</td>
<td>46 (100)</td>
<td>44 (100)</td>
</tr>
</tbody>
</table>

Missing = 4

While some respondents said that at least some backfill was available for any staff undertaking the training because more AMHPs were needed locally, others reported that there was equally no backfill for social workers undertaking AMHP training. In some LAs it depended whether the LA employed the trainees:

**The Local Authority offer 80% backfill for LA employed staff undertaking the training. They do not offer backfill for health employed staff.**

Survey 24

The survey also asked about the quality of the training available. The majority of survey respondents commenting on AMHP training and its university providers felt that training was excellent, of high quality and, while being intense and challenging, provided future AMHPs with a very good grounding to fulfil the role. In the interviews, several MHN’s also thought the training was of good quality, although challenging:

**It’s the hardest course I’ve ever done, and I’ve done quite a few, and it’s actually the best course I’ve ever done. So, it’s really, really intense.**

MHN AMHP 05

However, two also felt that the content in relation to mental health was not challenging enough for health professionals with many years’ experience,
although they did acknowledge the value of the elements relating to law:

I thought the course was poor for the nurses that got onto it. We were crisis nurses with years of crisis experience and the social workers had basically been sent onto it… Some were hospital social workers who had got no mental health experience.

MHN AMHP 01

Two respondents recommended that their provider involved employers as well as students in the development and improvement of the course. However, some felt that the training was too long and too academically driven, it was also said that quality varied across universities. One respondent reported that the LA had recently ‘identified significant gaps in the teaching and incorrect information being taught’ (Survey 38). Several respondents indicated that they had changed provider due to poor quality. There were no distinctive differences between replies from LA or MH Trust controlled AMHP services.

3.4 Union role

Only two interview participants, both OT AMHPs, said that a union had any positive role in supporting health professionals. This was in relation to Unison, which is not accessed by many health professionals:

Yes, but that’s difficult, too, again because of the health and social care split. So, the AMHPs are supported by the local authority UNISON and we have an excellent chap over there, who is very well aware of the intricacies of the role. He’s turned up to many forums, many meetings whenever there’s been an issues or debate about changing working practices. Unfortunately, as health staff, we can’t access him, so we have to use the health union representatives. They don’t understand the complexities that are involved.

OT AMHP 04

Well the unions were involved in the lobbying and I think the RCN were involved, but Unison provided us with a great deal of support at the lobbying level to promote this idea of role extension. Certainly, in the past the unions have been supportive, Unison have been supportive or are supportive of nurses and occupational therapists acting in that role, and role extension and competency-based practice and those kind of things.

OT AMHP 05

There were no positive views expressed about the roles of the professional bodies in encouraging health professionals to take up the AMHP role. For example, one nurse reported a negative response she had received from the Royal College of Nursing (RCN) which had indicated it could not support the nurse because being an AMHP was not a specialist nursing role:

Well I was in the RCN and I came out of the RCN because I don’t agree with the ethos. I joined UNISON, but I’ve not had any dealings with them. My professional body, the NMC, I did make contact with them because I decided to try and fight and get it recognised as an extra qualification on our registration. I thought if it went on there, they would have to respect us a little bit more, however the NMC sent it back to me in writing saying because this isn’t a role that only nurses can do, we don’t recognise it as an additional qualification.

RNMH AMHP 01

3.5 Awareness of professional background of AMHPs at MHA assessments

In interviews with professionals working alongside AMHPs at MHA assessments and with those who had themselves been assessed under the Act we explored the degree of ‘visibility’ of the AMHP’s professional background. None of these interview participants suggested that the AMHP’s professional background was formally disclosed to them at the assessment. Among the mental health professionals, one paramedic felt always aware of the AMHP’s background, but another said:

I guess your benchmark is the quality of the work they do and how much resource they’ve got to get the job done as it were, really. I’ve never thought to ask someone what their background is.

OT AMHP 04

In a similar vein, a police officer said: ‘To us, an AMHP is an AMHP’ (Other Professional 17). He and the other police officer interview participants were not generally aware of AMHPs’ professional
background. Two of the section 12 approved doctors did know the background of some of the AMHPs they worked with, but only because they had often worked with them and had built up relationships over time.

Among service user interview participants who had been assessed about half knew about the AMHP’s role at the time of their assessment; a social worker in each case. Important context for this finding is that, of these three participants, one was a social worker and one had been a section 12 approved doctor, meaning they had a prior familiarity with the people involved in MHA assessments because of their own professional background. The other four interview participants had not known about the AMHP role at the time they were detained, nor were they aware of the professional background of the AMHP involved. Again, important context to this finding is that individuals will be very unwell at the time of an assessment and so unlikely to be taking these factors on board: ‘I was in my own little world’ as one interview participant put it (MHA Assessed 09).

3.5.1 Did professional background influence AMHP practice?

While several interview participants among the ‘other professionals’ group said that professional background made no observable difference to the practice of AMHPs with whom they had worked, a number of distinctions were identified by others.

A section 12 approved doctor said that the social worker AMHPs were more likely to consider ‘broader social issues’ while nurses tended to focus on ‘the pure mental health side of it’ (Other Professional 08):

*I deal with probably hundreds of AMHPs, the social workers do tend to be a little bit more broader in their views on the other issues that might be affecting a patient, and slightly more open to the views of the family maybe. Whereas nurses tend to be slightly more focused on symptoms and the sort of stuff that us doctors tend to ask about.*

Other professional 08

Two doctors also reported that they were more likely to be challenged by social worker AMHPs than nurse AMHPs, although neither described this as a particularly stark distinction.

One police officer with considerable experience in the field of mental health policing identified two differences in the practice of the two groups. He suggested that social workers: ‘seem to be more preoccupied with rights, with the legal side of a detention, and safeguarding the person from a legal perspective,’ while nurses were focusing on the mental health of the individual (Other Professional 17). Interestingly, he also considered that social workers have:

*... a different standard, I don't know if that's the right phrase to use, when it comes to what's acceptable, what's reasonable in the community.*

Other professional 17

By this, he meant that where a nurse (and, he suggested, a police officer) might see someone’s living conditions and think they were not acceptable, a social worker might view them differently. A social worker may say:

*Their self-care is okay, I’ve seen much worse, whereas a mental health nurse would say, well, their self-care seems pretty awful to me.*

Other professional 17

He suggested this difference arose from social workers’ broader experience of home environments – a better idea of what is ‘liveable’, as he put it – and that this meant that a nurse might be more likely to detain than a social worker in such circumstances.
This section reports on motivational factors reported by study participants, both from an individual perspective as well as on a more general basis to highlight what study participants thought would encourage health professional to become and work as AMHPs.

4.1 Strong personal motivation required

The Registered Mental Health Nurses (RNMHs – qualified registered nurses with specialist training in mental health nursing) we interviewed tended to be highly motivated to become AMHPs and were passionate about the role. Nurses in particular had to overcome hurdles to become and practise as an AMHP. Hurdles described in their stories included negative attitudes from managers, some of whom appeared to believe that AMHP work was not of benefit to the NHS. Other factors were the different rates of pay and general views about the appropriateness of health professionals being AMHPs. These hurdles and barriers reflected the descriptions of other participants about how difficult it is for health professionals to become AMHPs, but it is useful here to show how individuals overcame these hurdles.

This RNMH AMHP described how after campaigning to be allowed to take the AMHP training for several years and finally succeeding, she had been told it was not possible for her to practise as an AMHP because of demands on the team. She eventually was allowed to work as an AMHP one day a month:

"When I actually got back to the Trust, the manager they'd put in charge of us knew absolutely nothing about the role and was inept. She basically said, 'Sorry, you're going to have to go and be a Care Coordinator.' I was like, 'What do you mean, I wasn't a Care Coordinator before I came on this, so why do I want to be that now?' She was like, 'We haven't got any other jobs.' I had to go back to the Community Mental Health Team as a Care Coordinator."

RNMH AMHP 01

Some RNMHs had to change jobs, or travel many miles to get jobs that would enable them to work as an AMHP, because the LA did not recognise nurse AMHPs:

"I'm employed here now as an AMHP, so I travel 60 miles round trip a day to come somewhere that will employ me as an AMHP. Closer to home I can't get a job as an AMHP because the council don't recognise nurses, but [this LA] did. I'm employed as an AMHP and I work in a crisis team. When I'm doing AMHP, I do crisis work, which is my bread and butter anyway. I mean straight after this I've got a patient, and then I've got another patient, and a potential Mental Health Act assessment around 3 o'clock. It just all fits together quite fine."

RNMH AMHP 01
4.2.1 More awareness of the role and that health professionals can become AMHPs

Many of the health professionals who were not AMHPs and other professionals we interviewed, as well as respondents in the survey, commented on the lack of awareness of the AMHP role and about the kinds of professionals could become AMHPs. Increasing awareness was therefore felt to be one important means of increasing numbers of health professionals taking up the role. For example, one survey respondent felt that more clarity about the role was needed and another added that information should include opportunities as well as obligations:

Ensure they know what the job entails and the challenges and demands. Give them the opportunity to show an interest. Make sure they know they will be on a rota and need to prioritise MHA work. Employers to recognise the opportunity, but also recognise the expectations on their staff and business.

Survey 51

The importance of awareness is highlighted by the fact that several non-AMHPs from each of the professions had not considered taking on the role and reported that their managers had not suggested it. For example, one LD Nurse felt that her focus had been on Mental Capacity Act work, having just qualified as a Best Interests Assessor, rather than thinking about becoming an AMHP:

If I'm completely honest it's not something I've ever, until I saw your email to tell me about the piece of research, it's not something I... It doesn't surprise me that learning disability nurses could be AMHPs, but it surprises me a little bit, just in that I hadn't thought of it or nobody had ever said to me, have you considered being an AMHP? If that's the case, yeah, it's... I guess the role I'm doing at the moment, I focus a lot on the Mental Capacity Act and Deprivation of Liberty Safeguards.

RNLD Non-AMHP 04

4.2 What would encourage health professionals to become AMHPs?

Many factors were identified by participants in all roles as possible encouragements of health professionals to become AMHPs. Most commonly mentioned was the need to raise awareness of the role especially about the fact that health professionals can become AMHPs.

Along similar lines, a manager of Approved Clinicians was sceptical as to how well known this potential role was among the eligible groups: ‘I think if you’re unaware and the path is not made clear to you, you’re not likely to go down that path’ (Other Professional 05). An AMHP trainer
was frustrated that, in his view, health professional AMHPs are insufficiently acknowledged: it was commonplace to attend AMHP training meetings and find national leaders talking exclusively about social workers (Other Professional 07).

### 4.2.2 Better reputation and profile of the service

Several participants also felt that work was needed to improve the reputation of AMHP work in order to attract more social workers as well as health professionals to the role. One interview participant said:

> I suspect in general, again this is supposition, but one would think that an attractive AMHP service would attract people. So, if it looks like a burnout sort of team that’s stressed, undervalued, is right in the heat of bed management and bed capacity issues, then it looks like a bit of thankless task then it isn’t going to be terribly attractive. If it looks like it’s well integrated with the crisis teams, there’s alternatives to admission and it’s a well-regarded, well led service, then you’d think, well that should be attractive to people who are looking for alternatives to working in the crisis teams.

Other professional 04

Going further, the participant questioned whether there was a sufficiently strong understanding of what ‘the right model of an AMHP service should look like’. In comparison with Crisis Resolution and Home Treatment teams where ‘there’s a number of models, self-assessment processes and accreditation schemes,’ he suggested:

> It just doesn’t seem like that sort of stuff is out there so it’s such a hidden role that’s so critical. But there seems like a lack nationally of research and practice infrastructure to support the role in the system. So that feels like a gap to me.

Other professional 03

### 4.2.3 Greater commitment from the NHS; good management arrangements

Asked what would encourage health professionals to become AMHPs, one interview participant emphasised the importance of NHS Trust buy-in to the policy initiated by the 2007 amendments to the MHA:

> What would encourage them was if NHS organisations, who basically are employing pretty much all of these other professionals, committed themselves to training them and committed themselves to the role, and they never have in my opinion. Hardly any have. Maybe there’s one or two. As I was talking to you, there’s one or two Trusts working in partnerships with local authorities.

Other professional 05

As a manager of Approved Clinicians put it, eligible health professionals needed more encouragement from their employers and managers and therefore:

> ... need to be encouraged by their organisation and to have that as a potential kind of career option, if you will, for the individuals concerned. That hasn’t been present from my working experience in [her area of England] anyway.

Other professional 04

An illustrative example of this theme came from a LA where a relatively high proportion of health professional AMHPs was found – one occupational therapist and three nurses, with 17 social workers. Through a training consortium of which the LA is a member, the AMHP Lead had overseen the training of nine or ten health professionals in the last decade. Asked how they accounted for this they said:

> I think that there’s always been an understanding, a general consensus that it’s a good thing to do within the Trust.

AMHP Lead 12

In counterpoint to this case, another Lead, who was enthusiastic about bringing in health professionals, faced obstacles which he thought derived from the Trust’s anxiety in relation to costs:

> What does worry me slightly though, or irritate me, is that I do have lots of nurses since I’ve been in post that have approached me enquiring about whether they can do the AMHP training. So, I ran a few sessions for social workers and also, I opened it up to health colleagues if they were interested.
4.2.4 Higher remuneration

Several interview participants and survey respondents felt that higher pay grades and/or additional payments would help increase interest in becoming an AMHP. This aspect will be reported on in detail in Chapter 7 ‘Remuneration factors’ (in relation to discouraging factors). And section 8.1 ‘Importance of remuneration’ (in relation to experiences of working as an AMHP). As with the suggested benefits of a heightened profile of the work of AMHPs, one RNMH argued that higher salaries would give the role more ‘kudos’ because of the social importance accorded to pay:

We would have more kudos really, I think, because people do look at pay structures and where people stand in society in relation to pay, we would have more kudos if we had a bit more parity within that.

RNMH AMHP 05

Factors preventing or discouraging health professionals from becoming AMHPs

As Chapter 3 has already detailed, prospective health professional AMHPs often have to overcome some barriers to be trained and to work as AMHPs. We will now explore these in more detail over the next three chapters. Many factors were identified as preventing or discouraging health professionals from becoming AMHPs. Broadly, these fell into three areas: organisational (Chapter 5); aspects of the role (Chapter 6); and remuneration (Chapter 7). Some had simply never considered becoming AMHPs, which also supports the case for efforts to increase awareness of the fact that health professionals can become AMHPs. However, for each of the discouraging factors mentioned, there were a small number of participants who argued the factor was not true or did not have the discouraging effect identified.

and was very honest with them that at the moment we don’t really have the mechanism to get them on the course...

So, I had about 10 nurses that came who were very interested in doing the training...I think if we were able to offer it to our health colleagues then we would have quite a number of people that would probably be willing and more than able to go ahead on the course. But, unfortunately, there just aren’t the mechanisms.

AMHP Lead 04

This was in the context of an AMHP team of whom between a third and a half were due to retire in the next two years.

One of the police officers interviewed pointed out that managerial impetus was required because of the ‘cross-border’ communication required between the Trust and the LA when setting up Trust-employed health professionals as AMHPs.

Consistency of job descriptions and conditions (which were described as very varied) across LAs, meaningful progression and career pathways were mentioned as factors that encourage health professionals to apply for AMHP training and later to work in the role. One of the ways of making it a more plausible step in an individual’s career path was, according to one other professional and a section 12 approved doctor, to write into job descriptions the expectation that the employee would undertake to train for the role – as often happens with mental health social workers.

Finally, AMHP Leads in the survey indicated that it was important to build structures that allowed AMHP-only positions, in order to provide a good service:

I don’t believe we have an adequate role unless they applied for an AMHP only position. I expect our pay scale and the care management function would dissuade Chartered Psychologists from applying.

Survey 12
The organisational context for mental health services, particularly whether mental health social work is integrated into health teams, was identified by many participants as affecting the likelihood of health professionals becoming AMHPs. There were arguments for and against the value of integrated teams in facilitating recruitment of health professionals as AMHPs. However, on balance, this was felt to be easier in integrated teams.

### 5.1 Return to ‘core business’

Two interview participants gave similar accounts of recent developments in service provision and of what they perceived as a trend of local authorities and Trusts concentrating more on their respective ‘core business’, to the exclusion of non-essential work. Such moves were ascribed to a number of factors. Chief among these were: funding cuts, the increasing amount of statutory work required of local authorities, and the ongoing effect of Payment by Results on NHS priority setting. In these participants’ views, the trend frequently led to the ending of section 75 (National Health Service Act 2006) agreements and so a reduction in the number of integrated teams.

One interview participant considered that this context rendered it less likely that health professionals would get employer support for becoming AMHPs because of weakened communication between the LA and the Trust:

\[A: \text{In order to consider training people as AMHPs, they will have to talk to the local authority again, and, by definition, they have reduced their ability to talk on a day-to-day basis... You might still have nurses pining for it, wanting to do it, but they won't get the support, I don't believe.}\]

\[Q: \text{They're less likely to get the support even though they want to do it?}\]
5.2 Integrated teams increase awareness of the AMHP role

Two study participants described how working in an integrated team had a positive impact on their awareness and interest in the role, which led to them thinking seriously about training as an AMHP. When questioned as to the significance of the integrated teams in which they had worked as an OT, before becoming an AMHP, one OT AMHP said:

Yeah. I think they were. I know in a couple of the other Trusts around us that the AMHPs are completely separate and yeah, I think then you just don’t get that spill over of interest in the role at all. It makes sense really, I mean I don’t think I would have been so drawn to it if I hadn’t seen [social worker AMHP] colleagues who I really respected and therefore been drawn into the role as a result of that.

OT AMHP 08

The value of seeing AMHPs working first-hand was also reflected upon by an AMHP Lead as he described a growing esprit de corps in their integrated CMHT (Community Mental Health Team):

Also, to some extent, to be a better team member, to add added-value as a team member as well because some of them [health professionals] do see the pressures that the AMHPs are under and think, if I did that it would ease the pressure on them as well as being maybe good for me and my future development. So, I think there’s something of a bit of a team spirit about it as well.

AMHP Lead 12

5.3 Separate teams increase complexity

To these observations on the positive effects of integrated practice were added participants’ views on the negative effects of non-integrated LA and Trust mental health teams. Many survey respondents and a number of AMHP Lead interview participants and one RNMH AMHP reported that separate LA and NHS Trust mental health teams created complexity in managing health professional AMHPs who were not working for the LA. The greatest reported problem identified, as reported above, was access to training. In addition, many AMHP Leads described NHS Trusts not releasing staff members to work as AMHPs on a rota system:

There is no incentive for health to invest in the service by paying for health staff to be trained as AMHPs and take part in AMHP rotas.

Survey 05

Others felt that this would also cause problems for those that organised the AMHP service. For example, one AMHP Lead believed that having AMHPs based in other teams might limit flexibility and therefore ability to cover the rota:

I guess it’s helpful for us to be flexible in our approach because some people do sometimes help and do assessments when they’re not actually on duty. I think that if you had somebody else from another organisation working as an AMHP in the area, the question for me would be how possible would it be for us to ask them, also, to occasionally help out?

AMHP Lead 08

This complexity was illustrated by one OT AMHP, who had found it hard to be allowed to start working on the AMHP rota after qualifying as an AMHP:

So, once I finished the course, it took a year to get my warrant. That seemed to be something to do with the Section 75 Agreement and they hadn’t really thought about non-social workers undertaking the AMHP role. Even though they put you forward for the training, there seemed to be a lot of negotiations behind the scenes. The social worker who did the course at the same time as me actually got on the rota nine months before me, even though we both passed at the same time.

OT AMHP 01

This AMHP Lead acknowledged that such problems could be overcome, through arrangements such as the LA paying for the time the worker spent working as an AMHP, although also argued that even with the full complement, there were not enough AMHPs:
5.4 Managing AMHP service easier in non-integrated teams

Notwithstanding the views expressed on the positive impact of integrated practice, this AMHP Lead and a small number of others felt that management of the AMHP service generally was, nevertheless, easier if the service was located in the LA rather than an integrated team:

*I think it’s made it easier, yes, easier to run the AMHP service... I can then say to [AMHP team manager], who’s the team manager, the AMHPs are now required to do more AMHP duty. She therefore needs to take that into consideration when she’s looking at allocating other work to the AMHPs because it’s not fulltime, they have other responsibilities.*

AMHP Lead 08

Survey respondents observed that Mental Health Trusts had no legal duty, or political and financial will to release staff members. In a similar vein, some AMHP Leads in the survey commented that AMHP work or MHA assessments were not compatible with Trust priorities. Many participants in the survey also commented that there was a lack of service level agreements that organised integration of staff members from other organisations. Additionally, several felt that there was no interest among senior managers to join up services:

*The role of the AMHP has always been viewed as the role undertaken by social workers, [...] there does not appear to be a joined-up approach to promoting and supporting none SW [social worker] AMHPs.*

Survey 26

And several AMHP Leads noted that managers of integrated teams seemed to find it difficult in practice to allow AMHPs to have reduced caseloads and time to complete MHA assessment reports, because of the general pressure on caseloads:

*I think they [managers of integrated teams, all nurses or OTs in this case] weren’t particularly happy about that because obviously our AMHPs have got a capped caseload, so you could have a social worker or a nurse with up to 30 people on your caseload, but if you’re an AMHP you’ve got a caseload of about 13 and they’re quite complicated cases. They are given the more complex cases but nevertheless it’s only 13, as opposed to double that, going up to 30 or 20. So I think there’s been a little bit of resentment, and I think when it comes to recruiting they clearly don’t want any potential AMHPs, they’d rather not have AMHPs because of their caseload.*

AMHP Lead 07
5.5 Fitting into a social care team
A couple of OT AMHPs and one RNMH AMHP described how difficult it was fitting into a team on an intermittent basis to take a turn on the rota. One said that it had been a long time after qualifying before she was able to start work and another felt excluded from decision-making:

*I think it’s very difficult being... Well, we’ve been classed as like an outlier and somebody who’s not formally within a team, because the way we are on the rota, we kind of come in three times a month and do a shift and then leave again. There’s a lack of continuity and handover and a lack of ability to impact on changes really.*

OT AMHP 04

One survey respondent added that being ‘between’ different teams hampered mutual understanding:

*Not having day to day working relationships with other disciplines makes it difficult to establish trust and support.*

Survey 26
The second main theme involved potential factors related to the AMHP role that discouraged health professionals.

6.1 Health professionals are not expected to become AMHPs

Many participants suggested that becoming an AMHP was almost expected of mental health social workers and was a clear advantage in terms of their career progression:

*I think you’ve got to have pretty good reasons not to be an AMHP.*

AMHP Lead 07

These participants were of the opinion that becoming an AMHP was not expected of health professionals and did not contribute to their careers in the same way. One RNMH who was not an AMHP, and another who was an AMHP Lead, used the metaphor of a 'rite of passage' in relation to social workers becoming AMHPs, which was not at all the case for health professionals:

*I was trying to think what’s the nursing rite of passage? I think in mental health it leans more towards when you get to a certain point you either become more medical or you become more psychological in mental health nursing... I think there doesn’t seem to be this obvious path of actually I’m going to do something like AMHP because then I think the question would be well what do you do after AMHP? I think that’s difficult for people to think about.*

RNMH Non-AMHP 03

Several RNMH AMHPs interview participants and AMHP Leads responding to the survey described how nurses, in particular, had been discouraged from training as AMHPs:

*No, I actually had the extreme opposite of they didn’t want me to do it because they didn’t want to pay for it. Interestingly, the service manager at the time was an occupational therapy background, but he didn’t think people from other professions should do it.*

RNMH AMHP 05

*Our NHS Trust will not release or support them to train, so this limits it to nurses employed by the LA.*

Survey 41

Two survey respondents questioned whether nurses had the relevant experience to undertake AMHP training and to meet the responsibilities of the role:

*A number of nurses have not studied to the required Master’s level and are daunted at the prospect. Also, some are put off by having to undertake a period of study as the pre-requisite to AMHP training.*

Survey 14

As with nurses wanting to become AMHPs, OTs had to show that they had the relevant qualifications and experience to undertake the training:

*They need to have been working in a community setting to have the relevant experience.*

Survey 39

In addition, several survey respondents indicated that OTs would not be released from their 'core' role as there was a lack of OTs in some areas:

*Unlikely that locally OT management would support as they have been very insistent that*
and the professional values of nurses, OTs and psychologists, but it appeared to be an important discouraging factor for some:

Our role is very much to enable. I mean if you think, for example, the work by Perkins and Slater on the recovery model, the whole basis of the recovery framework, including the work, for example, the person-centred care within working with people who experience dementia, is fundamentally grounded within a narrative of enablement, person centeredness. It’s not grounded within the traditional notion of control and treatment.

PSY Non-AMHP 06

One other professional concluded that there was no likelihood that psychologists could be attracted to work as AMHPs:

We should give up on psychologists… It [coercive practice] is anathema to them. I’m absolutely not surprised at all that psychologists haven’t taken up this role, because their whole professional training is around only working with people with consent. Whilst social worker AMHPs, we do our best, you have to embrace the fact that sometimes you have to take control and you have to act against people’s wishes.

Other professional 04

A more sanguine approach to psychologists doing AMHP work was taken by two interview participants who had been assessed under the MHA. For both, psychologists’ distance from the medical model was in their favour here:

Psychologists, yes. People who have some idea of family systems, just basic psychology. That’s what’s astounded me about psychiatry. None of these people were ever in therapy. I assumed that there would be a therapeutic component for these people with roles and power over people who are suffering from mental, emotional, social, psychological distress, and they don’t because it’s pure chemicals.

MHA assessed 03

When asked what might discourage health professionals from taking up the AMHP role,
another interview participant who had been detained under the MHA focused on coercive practice:

Well I think that, that you’re taking away somebody’s liberty, you’re potentially destroying a life, you’re giving them a millstone for the rest of their life, they will always be a sectioned patient, they will always be somebody who has been sectioned. It’s a terrible, terrible thing to do to someone, terrible.

MHA assessed 01

Finally, three survey respondents and interview participants observed that health professionals might lack the experience of applying social models of care to service users:

They are not trained in the social care model and may not be in a position to challenge medical recommendations and look at the least restricted options.

Survey 18

6.4 Anti-medical model perspective in training and practice

A small number of OTs and RNMH AMHPs and AMHP Leads, both in the interviews and the survey, felt that there was still an anti-health perspective in AMHP training and practice. For example, one AMHP Lead was very concerned about the impact of what she saw as ‘demonisation’ of the medical model, which she felt could be very off-putting to health professionals:

If we have nurses going into this, we stop the demonisation, as it were, of the medical model of practice because, certainly speaking as somebody who has delivered training into AMHP courses and I was a Best Interests Assessor until about a year ago and worked with that, the training very much demonises the medical model and highlights the social care model.

AMHP Lead 09

A police officer reported coming across the view among social workers that the AMHP role was only suited to their profession. Although he aired the possibility that such views were to be found predominantly among older members of the workforce, he had also come across this perspective being implemented in local authority policy:

‘Cause some nurses, and indeed some AMHP nurses have said they found local authority,... some local authorities have just categorically said, we don’t want nurses as AMHPs in this area, full stop. They’re fundamentally opposed to the idea that it should be law and because it’s a choice we can make to do it, we’re not doing it. Some nurses have therefore struggled to get any funding to do the qualification that would then allow the practice.

I don’t know how widespread that is, it’s just been an individual couple of authorities.

Other professional 01

One AMHP Lead interview participant embodied the perspective the police officer referred to:

I think we haven’t really encouraged health professionals to become AMHPs because I think we’ve wanted to, where possible, despite the Mental Health Act we’ve wanted to retain that role for social workers because we believe that’s why it was originally for social workers because of that independence and that social perspective.

AMHP Lead 14

This Lead asserted that the policy was not related to funding problems at the Trust: it had been the position of the mental health management team since the reforms had come in and it was adhered to despite recruitment difficulties.

Several survey respondents and interview participants observed that health professionals might lack the experience of applying social models of care to service users:

They are not trained in the social care model and may not be in a position to challenge medical recommendations and look at the least restricted options.

Survey 18
6.5 Work pressures, being on-call and working unsocial hours

A small number of participants felt that the unsocial hours required (many AMHPs described having to finish reports in their own time, or not finishing work until late at night) could be off-putting for some health professionals:

You can be contracted for a 37-hour week and your core hours may be 9 to 5 but if you’re an AMHP and this is the way that we would operate and it’s my understanding most AMHP services work like this, if you commence a Mental Health Act assessment, you can continue with it. So if you started at 3 o’clock and you’re still busy with it at 5.30, you can’t walk away. So I think those kinds of features of the work can be unattractive to people.

Other professional 05

A small number of AMHPs and AMHP Leads commented on the stressful nature of the work, which carried a risk of burnout. This was seen as a particular risk for full-time AMHPs, but also because of the shortage of AMHPs. The stress partly arose as a result of the crisis nature of the work, which for some was also an attractive aspect:

So all your morale and your motivation if all you’re doing is going from one crisis to the other, which is essentially what we are doing. We’re very much the last resort and we’ll say, have you tried this, have you tried that? Certainly, one of the locum AMHPs whose been here for as long as – he’s been here for about six/seven years, he’s actually saying to me when he retires he’s going to go into analysis because he feels as if he’s absorbed so much trauma from everyone else that he just has to have an outlet. I think it does that to you, doesn’t it?

AMHP Lead 07

Interestingly, one mental health manager argued that there was a problem in the way the new roles had been set up in 2008: the thinking behind the AMHP role had been too dominated by a social care perspective (‘the panels were essentially social care,’ AMHP Lead 09), while the Approved Clinician and Responsible Clinician roles were fashioned in such a way that made it difficult for anyone other than doctors to take up the position: of the 6798 Approved Clinicians only about 1% (n=63) are not medical doctors (Mosley, 2018).

Finally, in contrast to the widely held view that the social perspective is vital, one interview participant who had been detained under section 2 MHA 1983 said that the AMHP role should not exist. Detaining someone under the MHA, she argued, should be a purely medical decision; and the exclusive preserve of psychiatrists. It followed that none of the eligible health professionals should be doing the work, since none of them were qualified or acceptable, in this participant’s view.

AMHP Lead 07

As with this Lead, a number of other participants focused on factors that were not specific to health professionals. One of the interview participants who had been detained under the MHA focused, in this regard, on what she called the ‘judgement call’ of whether to detain:

It might put people off the fact you’re going to have to be in a position where you take someone’s liberty and there are consequences of that and...
Potential candidates appreciate the value and worth of the role; however, most are put off by the wider 'environment' in which the AMHPs have to operate (specifically section 12 doctor shortages, bed shortages and ambulance delays) which frequently extends the working day beyond the bounds of reasonableness.

Another interview participant who had been detained also referred to this central element of the work:

You have a very large power sitting in your grasp and it takes an amount of bravery I think, that not many people have.

AMHPs also face pressures from families who may have a particular view about the appropriate outcome of a MHA assessment: this is another pressure of the work. One interview participant, who had elected to be admitted informally, commented on this pressure:

... the fact that often families are dissatisfied if... [the AMHP] walk[s] away and say[s], no, we can't detain this person and indeed my family were very unhappy that I wasn't detained.

A section 12 approved doctor alighted on the potentially grave repercussions of making a wrong decision as being a likely disincentive.

Many survey respondents also commented on the work pressures and explained the negative impact on take-up of the role, again not only by health professionals:

Workload pressures on all community MH professionals deter all professional groups (including SWs) from taking on an additional responsibility.
Remuneration appeared to have an important and mainly negative effect on health professionals’ motivations to become and continue working as AMHPs. In addition to simply increasing the amount of money paid for the role, which was proposed to be influential in terms of motivation, as noted above, several factors about remuneration were identified. Factors relating to remuneration identified as discouraging health professionals are reported in this section. The overall importance of remuneration and suggestions for appropriate levels are reported in Chapter 8: Working as an AMHP.

7.1 Inconsistency of pay across the country
The lack of consistency in pay locally and nationally was mentioned twice in the survey, by one AMHP Lead and a RNMH AMHP and by one other professional interview participant, as a factor that made it difficult to recruit health professionals as AMHPs:

I think that the issue is there is no consistency across the country in what the pay would be. That, I think, is something that needs to be attended to, this is what the rate of pay will be therefore... they’ve got the single structures now of the local authorities but each of them have got different remunerations to those gradings... unlike the NHS that have a single grading. This is the pay across the country if you are this band.

Other professional 09

There is not consistency locally with the different employers having different views on remuneration leading to disparity.

Survey 45

There seemed also to be some concern about different rates of additional payments for undertaking out-of-hours AMHP work:

There should be a local standardised rate for AMHPs undertaking assessments out of hours or as additional duties, for example other areas pay AMHP’s £150 per assessment when they undertake assessments in addition to their usual job.

Survey 28

7.2 How remuneration is calculated
Whether the remuneration was paid in relation to extra increments or salary banding, or getting a flat fee or allowance for being on the rota or concerns about wage parity with social workers were all raised as potentially discouraging health professionals from continuing to work as AMHPs:

It’s not as much as social workers get in terms of their incremental... When a social worker qualifies and they go up certain points up on their scale...

OT AMHP 02

A small number also felt that getting a flat rate, as a salary addition, for being an AMHP, was unfair since it was unrelated to how many days an AMHP was working on the rota:

The frustrating part is-. So at the moment, I work two days a week on the rota. That’s all I do, I don’t do any other work. But you get your statutory AMHP allowance whether you do one day a week on the rota or two days a week on the rota or three days a week on the rota. So in some ways, it does seem a bit unfair but it’s what it is. I think it’s not unreasonable. It’s better than it used to be.

OT AMHP 01

However, I think we are so left on our own out there. When the chips are down, I know that you are on your own, there’s not a psychiatrist to be seen in sight and we’re not paid enough. It’s as simple as that. How they that do that if it’s per
Especially since every time I take a doctor out, I give them £250. Maybe we could pay less to the doctors and pay the AMHPs a little bit more [laughs]?

RNMH AMHP 05

Two survey respondents also considered that the payment for a MHA assessment should be equal for doctors and AMHPs.

RNMH 01

7.3 Discrepancy between doctors’ fees and AMHP remuneration

The discrepancy between AMHP remuneration and doctors’ fees for MHA assessments was mentioned as a discouraging factor by a small number of participants from different professional groups. For example, one OT AMHP highlighted the large difference in pay between doctors and what she was paid (£175 per assessment for doctors compared with £125 a month no matter how many assessments she did) as a frustrating part of the work:

[Doctors’ part in MHA assessments], which can last half an hour, 45 minutes. When you think of the work that the AMHP does, but the AMHP is at work on their 9.00 to 5.00 job, you know. I work 9.00 to 5.00, and if we actually have a duty doctor on shift, it’s part of their job, they don’t get... but if we needed a Section 12 doctor, an additional doctor, we don’t have one, then that’s what they get (£175 per assessment).

OT AMHP 02

There’s a lot of responsibility in, obviously, doing AMHP work. There are lots of legal requirements above and beyond what your... and with the £125 a month before tax is... I think anyone would think it’s a lot of responsibility. The training that you do, it’s a very intense course that you do. There are legal expectations in terms of your training. There are legal expectations you need to do. There’s a higher likelihood you may end up in some sort of court situation for making a decision or not making a decision, which has happened to colleagues. You kind of think, wow, it’s not a lot of... It doesn’t equate, for me.

OT AMHP 02

7.4 Health professionals are unaffordable as AMHPs?

Participants in the survey and interviews discussed the fact that staff members in the health sector often earned more than colleagues in LA social work. They felt that the lower pay level discouraged some health professionals from taking up the AMHP role:

AMHPs are paid less than health colleagues for more responsibility. Why would a nurse for example take on more responsibility to have a pay cut and a change in employer?

Survey 08

Difficulties about remuneration in relation to recruiting psychologists as AMHPs were especially exacerbated because of the fact that these professionals earned more than social workers and even those nurses with the level of experience required to train as an AMHP. This made it uneconomic to pay psychologists to do the ‘chasing around’ involved in MHA assessments:

Because as well, if you looked at a psychologist going, well by the time the psychologist has got the amount of experience that would enable them to go and train to be an AMHP, generally they’re [band] 8As. Well we’re certainly not going to be paying somebody 8A money to do an AMHP job, are we?

AMHP Lead 09

One psychologist mentioned that once a professional has reached a level of seniority, then AMHP work is not attractive nor of benefit to one’s career:

It feels like perhaps it is for somebody who is earlier in their career, if they’re wanting to think about different opportunities that may help in the longer
This aspect was also discussed in a survey comment, showing the divide between salaries for the different professions:

I would like to see NHS-employed AMHPs to have additional increments however this will make the divide between salaries in health and social care wider.

Survey 08

However, one social worker manager noted maintaining their work as an AMHP allowed a practitioner to 'keep their hand in', carrying out concise pieces of work whilst also moving up the management ladder:

I think it also makes it possible for people to stay actually in practice as senior social workers and not go into management because it gives another pathway. Whereas I see colleagues in other specialism who really like practice but there's no other way of earning more money unless they become managers. So I think it's helpful in that way.

AMHP Lead 10

7.5 LA salary levels do not match NHS bands

Where NHS salary bands and social worker grades did not match, this could make employing nurses and OTs as AMHPs problematic, resulting in health professionals and social workers earning different amounts for performing the same role. This was mentioned by several AMHP Leads:

I think that you would put a lot of people's noses out if you tried to pay other people more, but I think that you would have to offer... I guess if you offered it to a health employed member of staff as an alternative to taking on management responsibility as a way of getting to band 7, that would work. I don't think that band 7, it probably goes a fair way above our top AMHP salary. It's within the banding, I guess our AMHPs are probably paid at lower band 7.

AMHP Lead 08
This section reports aspects of the experiences of health professionals working as AMHPs, in addition to the encouraging and discouraging factors described above.

8.1 Remuneration

In addition to the discouraging factors relating to remuneration described in the previous section, participants’ accounts gave an indication of its importance and suggestions about appropriate levels.

8.1.1 Importance of remuneration

While never a directly acknowledged motivation (amongst RNMH/RNLD and OT AMHPs), partly because the amount of money was not considered sufficient to compensate for the extra responsibility and unsocial hours, remuneration was still an important factor for interview participants and survey respondents. Table 6.1 shows that over three quarters (n=38, 78%) of AMHP Leads responding to the survey felt that rates of pay were either ‘very important’ (n=17, 35%) or ‘important’ (n=21, 43%). A further five AMHP Leads (10%) felt pay was ‘moderately important’.

For example, while initially saying remuneration did not matter, OT AMHP 02 acknowledged that removing the extra salary that had been negotiated would make her wonder about whether to carry on doing assessments:

> Obviously, if they’d say tomorrow, I’m taking it away, I think I’d have a bit of a, hang on a minute, but as it is at the moment, if it was to stay as it is, then it’s not an issue.

OT AMHP 02

Also, some health professionals received no extra remuneration for being an AMHP. This was seen as a clear negative and if it was not preventing health professionals taking up the role, it was frustrating and provided no incentive to think about training:

> But it wasn't promoted, I got no extra money. The social worker AMHPs that went back got an extra grade, and they got remuneration for being on the duty rota. I was already at top Band 6 and got not a penny. I wasn’t recognised, no-one recognised that we’d gone away and we’d done this. It was really frustrating.

RNMH AMHP 01

But there isn’t any monetary incentive. I’m not paid any differently, whereas other social workers or other AMHPs would be. There isn’t any pay incentive.

OT AMHP 04

Several survey respondents commented that for taking on the additional responsibilities in the AMHP role there should also be additional remuneration. This comment shows the potential impact on health professionals’ interest in AMHP training and work:

> "Obviously, if they’d say tomorrow, I’m taking it away, I think I’d have a bit of a, hang on a minute, but as it is at the moment, if it was to stay as it is, then it’s not an issue."
One survey respondent felt that additional remuneration would show an appreciation of undertaking further qualification, as well as the pressures that came with the AMHP role:

"An additional payment makes the role more recognised as a specialist role and acts as an enticement for those who already have a high caseload."

Survey 27

One RNMH AMHP suggested a minimum of £40k a year, which is approximately the top of Band 7:

"I think a minimum of £40,000 a year is roughly about how much should be paid. If you look at the responsibility of the role, and the stress and the longevity of it. I think it should be paid as such."

RNMH AMHP 01

8.1.2 Appropriate remuneration

Most interview participants and survey respondents placed the appropriate remuneration for health professional AMHPs at NHS Band 7 or between Band 6 and Band 7, which would mean an annual salary of up to £35,577 or payment pro rata for time spent on AMHP work. Table 6.2 shows that, of the 45 AMHP Leads who gave an answer in the survey, over three quarters (n=35, 77%) suggested NHS Band 6 or 7 as an appropriate rate of pay for an AMHP. The highest number (n=18, 44%) felt Band 7 was appropriate; over a quarter (n=11, 27%) suggested Band 6; and one in seven (n=6, 15%) suggested somewhere between Band 6 and Band 7. Two AMHP Leads suggested Band 8 was most appropriate, as a result of the work being at Master’s level (although this was felt to be unsustainable by one AMHP Lead who was interviewed). Three of the four AMHPs who gave ‘other’ answers, felt that health professionals should be paid the same as LA AMHPs, and one felt they could be paid higher than their LA colleagues, but was also concerned about the possible problems that might ensue from this inequity.

Table 8.2: What would be a reasonable rate of pay for health professional AMHPs?

<table>
<thead>
<tr>
<th>NHS Band</th>
<th>No.</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>6</td>
<td>11</td>
<td>(24)</td>
</tr>
<tr>
<td>6-7</td>
<td>6</td>
<td>(13)</td>
</tr>
<tr>
<td>7</td>
<td>18</td>
<td>(40)</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>(4 )</td>
</tr>
<tr>
<td>Don't Know</td>
<td>4</td>
<td>(9 )</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>(9 )</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>45</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Missing = 6

Survey 43

8.2 The AMHP role fits with level of experience and skill

In contrast with the critiques of health professionals’ abilities described in the section above and some reports of an ‘Anti-medical model perspective in training and practice’, many nurse and OT AMHPs felt that they were well qualified because of their experience of working in the mental health field. They felt able to adopt a social perspective on the situation, were in the main happy about challenging doctors, and had an interest in the role. Two felt that as experienced RNMHs, the mental health aspects of AMHP training had been set at too low a level. This RNMH was clear that her experience was a good grounding, and that she had developed the right kinds of skills:

"When you’ve worked for that many years, you actually have done most things, and I think the AMHP role actually draws on the knowledge from all of the skills learnt over the years and all of the background, and it's the only thing that cohesively does that."

MHN AMHP 05

Several interview participants in the ‘other professionals’ group agreed that health professionals were able to bring the skills and perspective
associated with being an AMHP (and outlined in the 2008 regulations) to their work. Drawing on experiences as an AMHP trainer, one interview participant said:

*I don’t see a social perspective as unique to social workers. When I was involved very early on with one of the first people who… and it was a nurse and then, later, an OT on another course that did training, the nurse particularly stood out on the course as having the best value base. There were about a dozen people on the course, and it was the nurse who had the strongest value base…*

Other professional 07

Furthermore, for a small number of interview participants, individual characteristics were felt to be of more importance than professional background. For example, a paramedic emphasized the importance of personal qualities to the AMHP role, arguing that these could be found among any of the professions:

*A: So once you’ve ruled out any medical issues, and it is a mental health focus thing, then the priority is to get that person to somewhere where they can be treated in a most humane and sensitive and practical way possible really. I think those skills are skills that should be arguably in all those professions…*

Q: Yeah, so that might well cut across professional backgrounds really?

A: Yeah, I think it does, absolutely and it’s almost like the person doing the job is, in terms of their personality and their communication skills and things, is at least as important as their technical knowledge.

Other professional 12

This view was echoed by two interview participants who had been assessed under the MHA:

*Well it’s more down to the individual rather than the job title, would be my view. However, fancy the job title is, if they’re not sympathetic then…*

MHA assessed 09

A section 12 approved doctor indicated that he thought that mental health and learning disability nurses were likely to embody an empathetic approach by virtue of their ongoing experience with people in their patient group. The independent consultant, who was more sceptical in relation to nurse AMHPs being able to engage with the social model of mental illness, saw occupational therapists as being a particularly good fit for AMHP work because it is ‘fundamental to OTs’ training, the social model’ (Other Professional 04).

8.3 Challenging doctors/psychiatrists

Participants in interviews and in the survey repeatedly acknowledged the possibility that health professionals might find it more difficult to challenge doctors or psychiatrists involved in the assessment, perhaps as a result of a lack of independence, this was particularly said of nurses working alongside psychiatrists:

*There is the potential that Nurse qualified AMHPs could apply a medical model very similar to the assessing doctors due to their professional training as a nurse.*

Survey 28

*Medical model approach - some nurses still hold this strongly (but not all) and view people as patients. [They] may be unwilling to challenge psychiatrists where required, but this wouldn’t be a given and not necessarily all nurses.*

Survey 51

So I think social workers tend to find it easier to take on the role of being a bit challenging and disagreeing with consultants and more senior clinicians. I think for the nurses particularly, depending on where they’ve come from and how much time they’ve spent in community work, I think that can be challenging because people worry...
8.4 Immediate nature of AMHP work

As in the literature focusing on social worker AMHPs (Watson, 2016), several health professionals enjoyed the crisis element of AMHP work. For example, one RNMH enthused about the experience of the work, in terms of the variety and the sense of ‘living on the edge’:

I love the work. It’s as simple as that. I love it. You never know what you’re going do you in the morning. The day unfolds as it unfolds, and you deal with it as you go along which is a bit about my challenge thing that I quite like that living on the edge not quite knowing what’s going to come through the door next.

RNMH AMHP 05

Two of those interview participants who had been assessed under the MHA also highlighted the intrinsic interest of acute psychiatry as being a likely motivating factor for AMHPs wanting to do the work.

Again, in line with elements of AMHP work valued by social worker AMHPs found by Watson (2016), several health professionals felt that the impact on people’s lives was more evident in AMHP work compared with other aspects of their job:

I enjoy-. I don’t know if it’s enjoyment, but I always feel quite good about making the right decision and justify things to myself, I’m quite a reflective practitioner. I will kind of reflect and then adapt my practice suitably.

RNMH AMHP 01

A contrary view was expressed by an interview participant who had been detained under the MHA. Reflecting on the fact that he had not seen the AMHP in charge of his MHA assessment subsequently – which was typical of the interview participants in this group – he considered this might be a drawback for some (as it was for himself):

You’re not going to see the impact of your work unless somebody tells you, and I’d like to see the AMHP. I’ve spoken to people who worked with me on the ward and I’ve had the opportunity to speak to those people and I’ve had the opportunity to say
8.5 What hinders AMHP practice?

Four hindering factors were identified, which related to AMHP work in general, rather than being specifically about health professionals working as AMHPs. Perhaps the most important was the shortage of AMHPs, which was recognised by many survey respondents and interview participants. Two factors were related to difficulties created by other shortages and wider structural problems and another was linked to the impact on the professional development of working full-time as an AMHP.

8.5.1 Shortage of AMHPs

Table 6.3 shows that about three quarters (n=38, 78%) of AMHP Leads thought that the number of AMHPs in their area was not sufficient.

| Table 8.3: Is the current number of AMHPs sufficient? |
|----------------------------------------|--------|------|
| Yes or No                             | No.   | %    |
| Yes                                   | 11    | (22) |
| No                                    | 38    | (78) |
| **Total**                             | **49**| **(100)** |

Those that felt they had sufficient numbers of AMHPs said that they employed enough staff to undertake assessments when needed, though some said that numbers had been reduced due to austerity measures. Several of those answering that numbers were insufficient said that they had experienced problems when recruiting AMHPs; some believed that there was a shortage of AMHPs nationally. In addition to staff members retiring from the post due to age, some also experienced a heightened need for AMHPs due to an increase in the number of assessments. A great number of survey respondents also indicated that the AMHP workforce decreased due to conflicts between caseloads and AMHP work:

People are getting so much more unwell than they used to before they get admitted because there is a pressure to try everything else first. So whereas 20 years ago I think perhaps most of the ASW (Approved Social Worker) role, I think we perhaps saw ourselves as the defenders against the power of the mental health establishment and making sure people didn't get admitted unless they really needed to. It feels like now AMHPs are spending much thanks to some of those people. But I haven't had the opportunity to say that to the AMHP.

MHA assessed 01

8.5.2 Shortage of ambulances and beds

One comment in the survey, and replies from a small number of RNMH and OT AMHPs and one OT non-AMHP, focused on the problems created by difficulties arranging admissions as a result of the shortage of beds that consequently made good AMHP practice more difficult:

The bed situation. I bet that’s what everyone said. The bed situation is the biggest barrier. The frustration of everyone screaming at me that they want a Mental Health Act assessment, but they’ve got no bed.

RNMH AMHP 01

There is a shortage of beds, warranting is taking longer which puts additional pressure on the AMHPs.

Survey 18

I have waited, the longest was nine hours for an ambulance for somebody who was very unwell, and I’m the only person left with them because everyone else has long gone. So that is one of the most difficult things but not here.

RNMH AMHP 05

One AMHP Lead summed up how this situation had changed over time, in that AMHPs were more likely to be arguing for detention because of the focus on community treatment and the shortage of beds:

...it was deemed [x] was the number of 'sufficient' AMHPs but these are decreasing with people surrendering their warrants due to competing pressures, or not maintaining practice because of the structures of work allocation in this LA.

Survey 02

8.5 What hinders AMHP practice?

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Missing = 2

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MHA assessed 01
she practised as an AMHP, the importance of good support from both these managers was particularly valued:

Yeah, I was as well supported by health as I was social care…. Regular updates, regular supervision, feeling part of a team, encouragement, support. I’m lucky that I’ve got all that. Dialogue, always having a bed available, the doctors… having really good doctors.

RNMH AMHP 08

Another RNMH felt generally well supported (again by the social care manager of the AMHP service and her NHS team manager). She stressed the importance of being able to get support outside of regular supervision, after a stressful MHA assessment, for example:

I had an impromptu supervision the other week as well because I’d had a particularly rough assessment and it had upset me a little bit. My council boss was like, ‘I’ll come over and see you, and we’ll have a chat about it.’ Yeah, they’re there when I need them.

RNMH AMHP 01

Supervision of nurse AMHPs who also work in health teams appeared to be complex and reliant on continuity of managers and the initiative of the health professionals. Nurses need supervision in respect of their AMHP practice, other casework, if they are not full time AMHPs, and clinical supervision in their role as a nurse. For one nurse this involved a complex network of supervisors, which she had had to establish herself and which she felt was a great support:

So I have quite a complex network, which is how I’ve structured it to work for me. So I’m like that, it’s sort of I know what I need and I’ll sort it out. So I have my AMHP supervision from… the AMHP Lead. I have my case supervision from… my team manager. I have clinical supervision, nurse supervision, from a colleague who is a bed manager in one of the big hospitals nearby.

RNMH AMHP 05
A small number of health professionals worked as full-time AMHPs, for whom supervision was less complex. One OT AMHP described a range of supports available:

> So, I think I am very lucky that I am in a team which is a pure AMHP service, so we’re very, very focused on the AMHP role. I mean we have peer supervision groups with newly qualified AMHPs or the trainee AMHPs, and that’s really helpful. We also have regular, not regular, it’s bi-monthly actually, team meetings where we discuss changes in policies, any difficult cases, CTOs, social supervision, all those things.

**OT AMHP 07**

However, two OT AMHPs did not have any source of supervision for AMHP work, although one had set up an informal peer supervision group:

> We haven’t had any formal AMHP supervision. It is something that we have raised, well I have raised, because there were more of us, there was previously a nurse for a very short period but she’s no longer, she was on a short-term contract...I’ve organised, for myself, in the past, I’ve got a number of colleagues that I’ve known for years who are experienced AMHPs and I’ve asked them for support and have asked them, ‘Can we go for a coffee and can I bend your ear for an hour?’ It’s been done very much on an ad-hoc basis.

**OT AMHP 04**

Two survey respondents commented that having health professionals working as AMHPs added extra cost and difficulty as supervision needed to be organised with different employers when health professional AMHPs were employed by the NHS:

> [There are] logistical issues such as ensuring workers in a different organisation comply with our [LA] policies and procedures, also engaging in mandatory training and supervision etc.

**Survey 44**

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### 8.6.2 Support from colleagues

Informal support from colleagues is linked to job satisfaction (Gittell et al., 2008). Almost all health professional AMHPs felt supported by colleagues in social care AMHP teams and their own health teams (for those working mainly in health teams). This comment, from an RNMH AMHP was typical:

> There’s my colleagues, you can just bounce off ideas. There’s usually two of us on duty, so you kind of introduce yourself at the start of the shift and say, I’m working today, what plans have you got?

**RNMH AMHP 08**

A lack of opportunity to develop in the AMHP role was felt as a sign of a lack of support by one nurse: RNMH non-AMHP 04. This could be in terms of supervision or practical support when waiting for beds or an ambulance:

> So it’s things like there’s nobody there that can come and cover for you whilst you go and get a cup of coffee and go to the toilet. So, it’s the simple things, when you’re there. It’s quite hard then to remain calm, composed, supportive of the person that you’re working with.

**OT AMHP 01**
This final findings’ chapter presents the advantages and disadvantages of allowing health professionals to work as AMHPs, which reflect the discouraging and encouraging factors described in previous chapters. Some of these were mentioned by many participants, others by only one or two. They have all been included here to show the breadth of ideas about health professional AMHPs. Advantages outweighed disadvantages both in the number of participants raising them and in the number of different points made.

### 9.1 Advantages of having health professionals as AMHPs

In addition to increasing the potential number of AMHPs, which was mentioned by AMHPs and non-AMHPs as well as other professionals, many advantages were identified by participants. The main advantage noted by many participants was a widening of the kinds of experience and perspectives brought to the AMHP role. Many other advantages were mentioned by one or two participants.

#### 9.1.1 Wide range of experience and perspectives brought to the role (e.g. knowledge of physical health); open to different kinds of intervention and models

By far the most common advantage, mentioned by many AMHPs, non-AMHPs, AMHP Leads and other professionals and in the survey, was the inclusion of professionals with a wide range of experience to bring to the AMHP role. This was described by a manager of Approved Clinicians as being in line with the New Ways of Working best practice guide of 2007 (DH, 2007): ‘I think that was the underpinning kind of perspective – that people would bring different kind of knowledge base and skills into the pot, so to speak’ (Other Professional 05). It enabled managers to allocate cases appropriately and also enhance the support within the team. This AMHP Lead summed up their views on this advantage:

*I think that there’s a benefit to the patient at the centre of it all because different professions with different philosophies, take different approaches. We still come to the same conclusion at the end, but we come about it via a different philosophical route.*

AMHP Lead 09

Another example, repeatedly mentioned in interviews and survey comments, described here by a RNMH AMHP, is knowledge of medication, which could be useful in understanding the behaviour and responses of patients being assessed:

*So if you’ve got a deteriorating patient scenario, I think my nursing experience would tell me that if the risks are quite high to that deterioration to actually nip it in the bud and get the person into hospital quickly, because it’s much more easily turned around if somebody hasn’t been on medication too long and I think it’s in their best interests to do that, and I think it’s less restrictive.*

MHN AMHP 05

One of the section 12 approved doctors affirmed that nurses’ specialist knowledge could assist in choosing the least restrictive option (MHA Code of Practice: DH, 2015). A police officer went further (putting in doubt the idea, expressed above, that different professionals will come to the same conclusion), suggesting that social workers would be more likely than RNMHs to detain ‘personality-disordered, emotionally unstable, borderline personality disorder patients’:

*We seem to have a case where social workers will readily admit those people, whereas a mental health nurse has more of an understanding as to what’s... What evidence base is there for admitting that person? Well actually, we know it’s better*
The knowledge and skills of each of the three health professions were identified as being of value for AMHP work. Several survey respondents commented that nurses’ knowledge of different models of mental health and learning disabilities, including treatments and interventions, would provide an advantage in the MHA assessment process:

They are specialist practitioners which is useful when assessing those with LD so in keeping with good practice outlined in the Code of Practice to the Mental Health Act.

Survey 27

One of the section 12 approved doctors reported benefiting particularly from the input of specialist learning disability nurses who had assisted in assessments. Similarly, a paramedic interview participant stressed that nurses might bring a useful knowledge of how comorbidities may impact on the MHA assessment.

In interviews and in the survey the specific advantage of OT AMHPs was also highlighted. Two OT AMHPs and two survey respondents felt that OTs were more able to be AMHPs because their training covered a mix of medical and social perspectives and that they approached their work often from a holistic and person-centred perspective:

I think it’s one of the things that an OT gives you over other professions, is that you can change speciality. So, your training is generic, so you can go from physical to mental health or to children, whereas if you do nurse training you’re much more tied to a stream.

OT AMHP 01

It was also mentioned by several survey respondents that OTs could advise on equipment and meaningful engagement that could lead to less restrictive interventions. For chartered psychologists it was said that their knowledge of psycho-social interventions could add to the assessment process. A section 12 approved doctor envisaged that a psychologist AMHP would have a contribution to make in making MHA assessments of patients with personality disorder.

Shared training and exchange among qualified AMHPs were seen by one survey respondent as a great opportunity to enrich team knowledge, transfer skills and thus improve the quality of the service:

Learning would also be enhanced as a result of Health contributing to discussions with their unique perspective.

Survey 44

9.1.2 Improves practice within health teams

Having health professionals qualified as AMHPs was felt to be a general asset to Community Mental Health Teams (CMHTs) and other health teams in which they worked, for two AMHP Leads. This also meant that nurse and OT AMHPs were able to provide better support to their colleagues:

I think they enriched the service here while they were here, talking about different models, and also a bit more open to different types of intervention. I think we benefitted from them as a service.

AMHP Lead 07

Survey respondents felt that nurses working in hospitals added a good understanding of what happens in the hospital environment.

9.1.3 Ability to allocate the right professional (either because of profession or personal qualities)

Several survey respondents and one OT AMHP argued that having health professionals as AMHPs could lead to the allocation of the professional who was appropriate to the kind of situation, possibly also because of the kind of existing relationship as well as particular skills and knowledge of the profession:

Part of it was about saying we want the right people to be doing it and sometimes we believe that a psychologist or a nurse, or an occupational
The independent consultant broadened this point:

... one advantage is it would broaden the knowledge about the role of the AMHP across the whole multi-disciplinary team. I think one of the big issues across society generally, but also within mental health services is people are not familiar with the extent of the role of the AMHP, and the roles and duties that they have.

Other professional 04

In his view, this had substantive repercussions for practice. He referred to the response from other mental health professionals once the AMHP service has been engaged (while admitting that this was something of a stereotypical depiction):

... then people wash their hands of it, people who are already involved in the care with this individual/person/service-user/patient... Especially if the AMHP service is a centralised service, and they will say, well that's us done with really. I think that often causes tensions really and I think it's not good practice either.

Other professional 04

Having echoed this perspective, a LA commissioner argued that the AMHP service’s strong association with the LA had a negative bearing on how it was valued:

... the service is very much seen as a local authority responsibility, quite distinct from the rest of the crisis pathways and the crisis and acute care system. The AMHPs feel sort of under respected, they don’t feel valued and the function doesn’t feel valued in the system.

Other professional 03

One manager raised the point that children are currently not served well by current arrangements:

There are more children getting assessed annually than there are people with learning disabilities getting assessed under the Mental Health Act annually. We do not argue about the fact that there needs to be AMHPs in learning disability services but we are still arguing about whether there should be AMHPs in children’s services. That seems to me to be perverse.

Other professional 04
Psychologists tend to be powerful in organisations - having psychologist AMHPs would increase the visibility and importance attached to role.

Survey 50

9.1.5 Experience of crisis work
Many RNMHs work in Community Mental Health Teams (CMHTs) and have substantial experience of responding to urgent situations, which made these professionals particularly well suited to AMHP work, according to two survey respondents, one AMHP Lead and one RNMH:

In a lot of ways, you could argue that the nurses working in the CMHT in the crisis teams would be much better placed to take on the role, provided they've got that sufficient social perspective as well.

AMHP Lead 08

MH & LD nurses will have direct experience of those from their services and the medical role in dealing with any given diagnosis as well as having the experience of dealing with crisis and distress.

Survey 26

9.1.6 Facilitating street triage work and liaison
One police officer described practice in one area of England that involved joint working between police and the local Trust, where the nurse in the street triage team was also an AMHP. This meant that the police benefitted from being with a nurse with a good knowledge of the law, should the circumstances arise where that was called for. In addition, in instances where an AMHP was required, it was unnecessary to request for another professional to attend, thus facilitating the MHA assessment procedure.

Along similar lines, another police officer hoped that a reduction in the number of services involved would improve liaison and expedite procedures.

9.2 Disadvantages of health professionals acting as AMHPs
Comments in the survey identified some general disadvantages that applied to any health professional background when acting as AMHPs as well as to specific eligible professions. Participants in the interviews identified fewer disadvantages and tended to suggest them as possibilities, which they had not actually experienced or with which they disagreed.

9.2.1 Health professionals unable to bring a social perspective and be independent?
Chief among the potential disadvantages was the perception that health professionals would struggle to bring a social perspective to MHA assessments, although most felt that this was not a problem in practice. However, a small number did feel that health professionals would always be weaker in terms of bringing a social perspective:

In my opinion nurse/health professional based training is very different to that of social work training. Social work training gives a holistic and wide ranging theoretical perspective - it is whole person centred. Nurse/health professional training is more linear in its approach and primarily focuses on the medical model.

Survey 43

I think people do seem to do better are people who have had time in the community, partly because they were used to making autonomous decisions, whereas where I come across people who have all of their professional career in the mental health services has been on wards, I think they really struggle. [...] Some of the things that social workers take for granted about anti-discriminatory practice and an individual approach to people, and what it is that they want rather than what we know about the illness, I think sometimes can be quite challenging. I remember [...] a quite senior nurse said, [...] I think I want to do this because then I can pop down and sign the papers in A&E when there's someone on the 136. My immediate thought was I don't want you to be an AMHP because that's not your role. My concern was she could go and do the course and that is exactly what she'd do. She would be popping down and say, oh yes, okay and sign without really appreciating that this is somebody, this is an individual with a life. They're not just a mental health patient.

AMHP Lead 08

Survey 43

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reflection thought, yes, they were right. So I think mental health nurses are less likely to challenge that because of the hierarchy that exists.

Although it has all changed over the years, there still is an unspoken hierarchy that goes through nursing and medicine, and social workers are separate from it.

Two interview participants developed this idea of independence in relation to hierarchical relationships. One section 12 approved doctor reported:

I think what I have noticed is that everybody seems to be very good, but I think there’s a little bit of a reticence on the part of the people that aren’t social workers to challenge what other medical professionals have said. I don’t know. Again, that might just be my experience and it’s not something that I’ve noticed hugely. It’s just apparent from time to time.

In similar terms, the independent consultant stressed the need for ‘professional assertiveness’ in AMHP work and described (among nurses) a ‘risk of deference’:

... once you’re in the AMHP role you are outside the management structure, statutory. Whether you can actually bring yourself psychologically to understand that is another matter. ...I think that there is the risk of that not just the medical model versus the social model, but also the, what’s the word, deference, the risk of deference. ...I think the way the NHS is set up and the fact that the NHS remains a very much command and control organisation, I’ve got no doubts about that, nationally.

9.2.2 Inconsistency of AMHP practice

The flip side of the advantages of having multiple perspectives informing AMHP practice is that this might lead to inconsistency. This was mentioned by two psychologist non-AMHPs:
9.3 Extending eligibility to other professions

This section reports the views of participants in respect of psychiatrists, police officers and paramedics, and a small number of other professions who might be considered for the role. Apart from those paramedic interview participants who put the case for their profession, none of the interviewees and survey respondents argued strongly for the role to be extended to any particular profession. Rather, arguments were often put against this being done for a variety of reasons.

9.3.1 Overall views about extending eligibility

We asked survey respondents and interviewees whether eligibility for taking up the AMHP role should be extended to professions other than those specified in the 2008 regulations. Overall, about four fifths (n=38, 79%) of survey respondents felt that other professionals, such as psychiatrists, should not be allowed to become AMHPs. When asked to explain their answer, six respondents (13%) said that only social workers should be allowed to work as AMHPs. However, five respondents, who had answered that other professionals could become AMHPs indicated that this included any mental health professional. Interview participants mentioned lawyers, physiotherapists, speech and language therapists, workers in the voluntary sector, and non-professional carers as possible candidates for eligibility for the AMHP role. Also mentioned were service users and support workers.

It was a commonplace among study participants to stipulate that for this role people should have experience of working with people with mental health problems and their families, prior to the AMHP training. One nurse AMHP said:

> I think the only people that should do this job are people who have had a minimum of five years crisis experience, or a minimum five years mental health experience.

MHN AMHP 01

One interview participant who had been detained under the MHA promoted the idea of service users being trained as AMHPs:

> They could think about bursaries for training service users. I know of people who were service users who were AMHPs. There would be

PSY Non-AMHP 19
then the thing doesn’t work does it? It needs some kind of balance and regulation in order to keep it rounded.

MHA assessed 02

A former section 12 approved doctor, reflecting on the time they had been assessed under the MHA, echoed the stress on the role AMHPs have in challenging doctors’ views. This participant cast the distinction between psychiatrist and (social worker) AMHP in terms of their respective attitudes to risk and their resultant feelings towards the AMHP:

I did appreciate when I was being assessed that there was a social worker who would be inclined not to detain, would definitely be thinking, could this be managed any other way? A psychiatrist who might be thinking, there’s a bit of risk here and I’m going to take no risks at all, I’m going to detain. So, I appreciated that – I warmed most to the social worker who I knew was likely to taking the do-not-detain route.

MHA assessed 05

Ensuring the distinct role of the AMHP, with independence to challenge the doctors involved in the MHA assessment, was the main theme emerging in arguments not to widen eligibility. Arguments for widening were typically based on the sense that some individual professionals in these other groups are very knowledgeable and able to adopt a social perspective. Three professions were prominent, which may be due to the examples given in questions: psychiatrists, the police and paramedics.

9.3.2 Psychiatrists

The importance of separation of roles was the strongest argument put forward by participants who felt that psychiatrists were not suitable professionals to become AMHPs. As one AMHP Lead said, objecting to the prospect:

...we need the interface between AMHPs and psychiatry to offer rigour in the assessment process

Survey 06

A person who had been detained under the MHA stressed the value of the interface between AMHPs and section 12 approved doctors in making considered decisions:

...if you don’t have the AMHP regulating the views of section 12 doctors, or you don’t have the section 12 doctors offering a view to the AMHP...
they have an AMHP-like figure who basically hands out the bits of paper whilst we do all the thinking. When I came here it was quite a change when I first arrived here to get used to not being the ultimate decision maker, or my profession not being — and having to sit back and be told by an AMHP that didn’t agree with my assessment. That was a slight shock to the system initially, but I’ve grown to embrace it over time. So I do feel there is more to it than doctors’ narrow medical approach. I also like the fact that risk sharing process... There’s probably disadvantages, but my eyes were opened to the broader actions one should consider when I came here.

Interestingly, another section 12 approved doctor, who also valued the independence of AMHP decision-making, believed that AMHPs may in some circumstances argue for detention against the views of doctors (in seeming tension with the portrayal of section 12 approved doctors as risk-averse). The doctor made the point that NHS Trusts, which employ section 12 approved doctors, had a vested interest in limiting the numbers of people in hospital beds, creating something of a tension for these professionals and a further complexity in MHA assessments. Nurses, as Trust employees, may also feel this tension:

I think that that would be very hard to do because, essentially, you’ve got someone who works for the Trust, and because they’re a psychiatrist, they’re going to be paid by the Trust. Like it or not, the truth is that the Trust have different metrics that they want to meet. They don’t want people in hospital. They want to be using the crisis team or things like that.

While these participants typically founded their objections in the idea that psychiatrists were too embedded in the medical model perspective, participants who were willing to consider psychiatrists for the position suggested that this was not universally the case. Three AMHP Leads and two health professional AMHPs gave an account of psychiatrists along the lines of this one from a survey respondent:

...There are psychiatrists who are very person-centred and empowering in their practice and it would be unreasonable to have a blanket ban; but it would require careful management.

Survey 36

9.3.3 Police

The raised profile of the police in responding to mental illness in the community and the growing interest in the subject among some officers was acknowledged by a number of study participants. The value of role separation was also identified by two participants as being an important reason not to extend eligibility for AMHP training to police officers. For example, it was suggested by one independent consultant that the various professions involved in MHA assessments performed complementary roles. While AMHPs focused on maximising civil and human rights:

They [the police] have a role of social control, a very explicit social control role. I know the AMHP is a social control role as well, but... As AMHPs, we are constantly trying to minimise social control and maximise the involvement of the individual. The least restrictive option.

Other professional 04

A section 12 approved doctor spoke about his experience of the value of role separation as a reason not to extend eligibility for AMHP training to the police. This participant felt that it was important for the police to be seen to be outside the decision-making role, to preserve the positive reactions of people with mental health problems to the police, compared to mental health professionals:

I think police, no, because they have a particular role and I think that that muddies the waters too much. One thing that I notice doing the work that I do is that people often respond to the police much better than they respond to mental health professionals, perhaps because of their experience within the system. I think once you start to take away from that, then you lose something, and I think the police have a role in terms of executing warrants.

Other professional 10
A few interview participants were ambivalent as to whether this should extend to their becoming eligible for AMHP work – a paramedic, for example, had been impressed with the sensitivity of police officers to mental health crises. Two police officer interviewees, who certainly fell into the category of the ‘very interested’ in the role, as observed by MHA assessed 04 (above), did not rule out role extension. But it was also acknowledged by these interviewees that the police did not have sufficient background in advocacy and that their training fell a long way short of what is required. It was also suggested by one of the police officers that the independence of the role might be compromised where a patient was in a police cell and there was pressure on cell availability. This echoes the doctor’s (Other Professional 10) concern about the independence of doctors from NHS Trusts which have a certain interest in the outcome of MHA assessments.

9.3.4 Paramedics

Among non-paramedic interviewees there was some uncertainty as to whether paramedics were appropriate candidates to be AMHPs – the level of their training in mental health was often not known about. As with police officers and psychiatrists, some considered it unwise because it was thought that paramedics have a distinctive role, which should not be compromised. None of the survey respondents suggested that paramedics should be eligible, although five indicated that any mental health professional could work as an AMHP. A police officer interviewee did not rule it out, saying that the prospect might be seen in a similar light as the suggestion that section 136 MHA police powers should be extended to paramedics.

The three paramedics who took part in interviews pointed out that a significant proportion of their work involved mental health problems. A common feature of their practice was to initiate the sectioning process by starting to call in the parties involved in a MHA assessment. The profession was described by one paramedic as ‘very distinct and different from nursing.’ According to him, paramedics ‘operate autonomously, make their own decisions and challenge where necessary’ (Other Professional 18). He went on to list other relevant aspects of the paramedic’s role:

...patient advocacy, patient-centred care, dealing with complex situations, dealing with crisis,
recognising that the social component to the environmental component to all presentations of disease or behavioural concerns, these things are pretty much givens for paramedics.

Other professional 18

He described the workforce as largely made up of graduates and pointed out that some 30% are working outside of the ambulance service in other parts of the health economy. He suggested that AMHP paramedics might best be drawn from this element of the service.

Another paramedic argued that patients may benefit from greater continuity of care:

...from a patient continuity perspective so for example, if I'm with a patient that I think needs sectioning I then have to phone external people and I've just spent, for the sake of argument, two hours with this patient trying to create a rapport, a level of trust. Then I'm phoning outside people to come in, so that then breaks everything down again. I have to start again.

Other professional 13

The patient would also benefit from waiting less time, according to this paramedic. The same interviewee also reported that difficulty in getting hold of an individual’s social worker was often a problem and meant that paramedics were in a position to step in to facilitate assessments.
This research aimed to identify factors encouraging and discouraging the recruitment of mental health and learning disability nurses, chartered psychologists and occupational therapists as AMHPs and to explore possible means of increasing their uptake of this role. The research was commissioned in the context of these eligible health professionals currently making up only about 5% of AMHPs (Carson, 2018). Two limitations on the research need to be highlighted here. First, the sampling approach may have meant that participants would have had unusually strong views or vivid experiences. We did encounter AMHPs who were very enthusiastic about the role and had clearly been very motivated, which may have explained the strength of views. In addition, the low level of response to the survey meant that findings should be treated with caution.

In this discussion, we highlight the factors we have found in the research and identify those linked more strongly to the position of health professionals and those more associated with the generic nature of AMHP work. In the conclusion we suggest potential means of overcoming these barriers.

In the Introduction, we identified the current arrangement in which local authorities (LAs) have responsibility for running the AMHP service as a possible factor impeding the take-up of the role. This was borne out by the research. Participants noted complexities of support and supervision, an unwillingness on the part of some health managers to allow health professionals to take the AMHP training and a reluctance to release them to work on the AMHP rota. Some participants suggested this indicated a lack of commitment to the AMHP service from health trusts. The current placing of responsibility for the AMHP service on LAs may well contribute to a lack of commitment as there are no obvious incentives for health trusts to support the service. Also, in line with the previous research we outlined in the Introduction were the overall shortages of AMHPs (CQC, 2018) and low numbers of RNMHs, RNLDs, OTs and only one psychologist currently warranted as AMHPs (Carson, 2018). There remains a need to increase numbers of AMHPs, making it important to consider how to increase the number of health professionals taking up the role. The CQC (2018) review of AMHP services found that AMHP leads and AMHPs called for a register of AMHPs and a national job description in order to provide good information about the professional backgrounds of AMHPs across the country. This might help focus recruitment, although it was not mentioned by participants in our research.

Many of the factors identified as discouraging health professionals from becoming AMHPs appeared to be related to organisational factors, particularly the boundary between LAs and health trusts, or the complexities of managing multidisciplinary, integrated teams. Major changes to the organisation of mental health social work services, either having been returned to LA control within the last three years or plans to integrate social work services with a NHS Trust had taken place or were planned in almost half (n=16) of the LAs of the AMHP Leads responding to the survey. In a small number of LAs, in which mental health social work had returned to LA control within the last three years, there were plans to re-integrate. Such flux fits with the national picture. Lilo (2016), reporting on a national survey, found that 55% of the 102 (out of 152) authorities had a section 75 (NHS Act 2006) agreement covering mental health services. These agreements allowed pooled budgets between NHS Trusts and LA adult social care departments and the seconding or transferring of social care staff to NHS Trusts. However, many of these agreements have been dissolved over the past few years. In 2012, Community Care reported that two fifths of LAs were going to withdraw social workers from integrated teams and resume responsibility for mental health social work. The research also supports the idea that extra statutory duties for LAs created by the Care Act 2014 have
increased this tendency, as found by Lilo (2016) and McNicoll (2016). In addition, supporting health professionals to become AMHPs, may not be seen by LA managers as contributing to fulfilling these new LA responsibilities. Again, this supports the need to spread responsibility for AMHP services.

A constantly changing organisational context for mental health services (Lilo, 2016) is another factor that might be thought to affect the uptake of the AMHP role by health professionals. However, it was not clear in the current study, whether this had or might have an impact on recruiting health professional AMHPs, although it seems likely that the arrangements for being released for training or work on an AMHP rota, making decisions about rates of pay, arranging management and supervision across organisational boundaries, would become more difficult as organisational relationships are in flux.

Arguments were put in favour of integrated teams, which were seen as generating interest among health professionals working in direct contact with AMHP colleagues. However, difficulties in managing the competing priorities of health and AMHP service were also identified, which were ultimately the LA's responsibility. It was thought that LA-managed social work mental health teams made it easier to manage the AMHP service overall, but that separate teams made it harder to manage and support health professionals working as AMHPs. More broadly, there is little definitive evidence for the benefits of integrated or separate mental health teams, although some indications of better outcomes were found by Omer et al. (2015). There does not appear to be evidence about the impact of integrated or separate mental health teams on managing AMHP services.

Specifically, arranging cover for health professionals while doing AMHP training presented an important problem. This had prevented some non-AMHPs we interviewed from taking up the training and meant that some AMHPs we interviewed had had to work hard to persuade their managers to support them to do the training as there was no backfill available. Furthermore, some AMHP Leads reported that local mental health Trusts had a blanket ban on health professionals doing this. Most participants reported that training was funded by LAs. Again, the organisational change in mental health social work services may make LA managers more reluctant to fund their staff to become AMHPs.

There were also many aspects of the AMHP role and individual factors that discouraged health professionals. First was a generally negative image of the role and impressions of it being stressful work and involving unpredictable and antisocial hours. The CQC (2018) also identified the importance of recognising the value of the AMHP role as a means of improving AMHP delivery and this study suggests that this may help attract more health professionals to take up the role. All the matters identified in previous research (Coffey and Hannigan, 2013; Gregor, 2010; Watson, 2016) were raised: damaging therapeutic relationships; the AMHP role clashing with professional values; and the difference and potential conflict between medical and social model in training and practice. While experiences were mixed, the findings in this study suggest that these are still negative factors. A simple lack of awareness that the qualification was open to eligible health professionals was also frequently mentioned.

Remuneration appeared to be an important factor, although under present arrangements it was rarely given as a reason for taking on the role. It was important to participants that AMHP work was rewarded, given the extra responsibilities and time implications. NHS Bands 6 or 7 were suggested by most survey respondents and interview participants as being the most appropriate remuneration level for AMHP work. This created a problem given that social workers and nurses did not have matching salary scales, which could mean that health professionals and social workers would be paid at different rates for the same work, both locally and nationally. In general, it was felt that psychologists would have the lowest level of interest given their already higher salary, even if AMHP work is additionally remunerated.

How to arrange remuneration was also highlighted as problematic: mainly whether to pay by time spent on the rota and/or a fixed fee for each assessment, although this is more of a generic problem, which could apply to social workers as well. Inconsistencies about rates of pay and these kinds of detailed arrangements were also identified as factors making it difficult to interest health professionals in undertaking training and
recruit them as AMHPs. Again, these kinds of inconsistencies also created problems in recruiting social workers as AMHPs in some areas, where there was competition between neighbouring LAs. The discrepancy between payment to AMHPs and the payments to psychiatrists involved in MHA assessments were also raised as barriers. This is more difficult to address but seems likely to remain a factor affecting all AMHPs, as will many of the problems about pay. It suggests the need for exploring greater rationalisation of pay for AMHPs across the country, in order to avoid the discrepancies affecting overall AMHP recruitment in specific areas as well the recruitment of health professionals.

Many aspects of working as an AMHP described by interview participants and survey respondents were relevant to all AMHPs. AMHP and non-AMHP health professionals mainly felt able to take on the role, feeling it fitted well with their experience and skills and that they were quite able to take a social perspective. As with social workers, the crisis element of AMHP work was attractive as was the sense that the work has a direct (and ultimately positive) impact on people with mental health problems, which was satisfying. The flip side of this aspect was the sense of it being a stressful and difficult area of work.

The factors identified as hindering AMHP practice were also mainly generic aspects of the role, as opposed to elements specific to health professionals: stress and anti-social hours; shortages of ambulances and mental health hospital beds; the impact of structural societal problems; and the possibility that being a full-time AMHP might deskill professionals. While there were positive accounts of the supervision and support to health professionals AMHPs, arrangements were often complex in relation to different roles played by health professionals.

Overall, participants were very positive about the idea of allowing health professionals to work as AMHPs, identifying many advantages. Most commonly mentioned was the benefit of having professionals who could take different views and bring a wide range of experience, knowledge and skills to the work, which would also make it possible to allocate MHA assessments to the most appropriate professional, in line with Vicary (2016). It was also suggested that health professionals acting as AMHPs might have beneficial impacts on other mental health practice, also in accord with Vicary’s (2016) findings.

A number of disadvantages were mentioned, each by a small number of participants. First was the possibility that health professionals would be unable to work outside of a medical model perspective and bring enough knowledge of the social model to the role. This was raised by some AMHP Leads and also an OT, while many of the health professionals expressed certainty that they were able to deploy the social perspective. This research does not enable us to gauge how significant such views are in determining policy across English local authorities, or the relative zeal with which such policies are pursued. Finally, there was a fear that inconsistent AMHP practice might result from the involvement of health professionals, which is the flip side of the advantage of having a wide range of professional perspectives involved in the work.

There were more negative views than positive ones expressed about widening the professional groups eligible to become AMHPs. It was felt that psychiatrists in particular would not be suitable candidates, mainly because this was felt to weaken the separation of roles currently in place, especially the ‘challenge’ role of the AMHP. It was also raised as an objection about nurse AMHPs, although views about nurses’ ability and willingness to challenge doctors’ views were much more mixed. Similarly, there were mixed views about the police and paramedics being enabled to train and work as AMHPs. Potential confusion about roles was also the main reason for not extending the opportunity to work as AMHPs to these professions. However, there was also a view that some police officers and paramedics were ideal candidates, because of their experience and roles within mental health services.

Therefore, before any extension of the professions allowed to work as AMHPs is introduced, specific measures would be needed to focus on how to maintain this separation in training and in the organisation and management of AMHP services.
10.1 Conclusion

Overall, the research identified a positive view of health professionals acting as AMHPs. It seems likely that many health professional AMHPs have had to be highly motivated to overcome a wide range of organisational barriers and individual difficulties in order to take up the role. While some negative attitudes were uncovered, the main message appears to be that health professionals are thought to be able to work well as AMHPs, perhaps with the exception of psychologists.

A number of changes could help break down some of the barriers identified. Most fundamentally, would be creating a joint responsibility for LAs and health Trusts to run AMHP services. Short of sharing responsibility for the service, specific responsibilities for enabling health professionals working for health Trusts to take up training and ensuring that LAs agree to fund them (which may require extra funding) would help. In addition, national decisions about the amount to pay AMHPs and how to pay them would help general recruitment of AMHPs as would an overall increase in the amount paid. Providing a general pay enhancement for all health professionals acting as AMHPs, possibly similar to the enhancements linked to becoming a nurse prescriber, for example, might help make becoming an AMHP be linked with career progression for health professionals. Professional bodies, such as the Royal College of Nursing and Royal College of Occupational Therapists, appear to have had little or no involvement with encouraging health professionals to become AMHPs, according to the participants in this study. Engagement with these bodies, and regulators such as the Nursing & Midwifery Council, may also help to raise awareness of the role and create the impression that becoming an AMHP is an important means of career advancement and a rewarding role for nurses and OTs. However, changes to the organisational management of the AMHP services appear to be the most important means of improving the numbers of health professionals becoming AMHPs.
References


Care Act 2014 Chapter 23.


Appendices: Research Tools

1. Online survey
2. AMHP interview guide
3. Non-AMHP Interview guide
4. AMHP Lead Interview guide
5. Other Professional Interview Guide
6. People with experience of MHA assessment interview guide
Appendix 1: Online survey to AMHP Leads

Who wants to be an Approved Mental Health Professional?

Information sheet

We would like to ask you to take part in a research project. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what you will be asked to do. Please take time to read this information carefully and discuss it with others if you wish. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask us if there is anything that is not clear or if you would like more information.

Who is doing this research

The Department of Health has commissioned the Social Care Workforce Research Unit, (based at King’s College London) to carry out this research. There are five researchers from the Social Care Workforce Research Unit involved in this study. The leading investigator is Martin Stevens who can be contacted by email martin.stevens@kcl.ac.uk; telephone 020 7848 1860; or mail to Social Care Workforce Research Unit, King’s College London, Strand, London, WC2R 2LS.

Why are we doing this research?

Since 2008 mental health and learning disability nurses (hereafter ‘nurses’), psychologists and occupational therapists have been able to qualify as Approved Mental Health Professionals (AMHPs), in addition to social workers, who used to be the only type of professional able to qualify as an AMHP (which was formerly known as an Approved Social Worker). This research aims to study why these other professionals want to work as AMHPs and what might be preventing or putting them off taking on this role.

Why have I been approached?

You have been approached because you are a mental health manager in a local authority.

What does taking part involve?

If you agree to take part, please complete the survey below, which covers:

- Organisation and allocation of AMHP work
- Supply of AMHPs
- Experience of recruiting and training AMHPs and plans for the future
- Current policies or future plans to improve retention of AMHPs

In addition to this survey, we are interviewing: people with mental health problems and their family members; nurses, psychologists and occupational therapists who are working as AMHPs and those who are not; other mental health professionals and mental health managers.
**What happens to the survey data**

We will download the survey data and analyse it with the assistance of computer analysis programmes and produce reports and articles based on this work aimed at different audiences.

All names or places that might identify you or anyone else will be not be used in any reports or presentations about the research. Data will be stored on password protected computers (in accordance with the Data Protection Act 1998). The data will only be accessible to the researchers involved in this study. Personal data will be stored for seven years after the study ends and then destroyed. We would like to use anonymised data and quotations to illustrate points we make in publications and presentations. We will make every effort to ensure quotes do not identify you.

We will not reveal your identity to anyone else, unless you tell us about harm to an adult at risk that has not been addressed or if you tell us about professional negligence or harm to an adult at risk. If this does happen, we would have to inform the appropriate authorities, although we would usually discuss this with you first.

**Ethics?**

This study has been reviewed and was approved by the London – Camberwell St Giles Research Ethics Service Committee.

**What if I have questions**

If you have any questions or would like to discuss any concerns before agreeing to be involved, please contact Nicole Steils: nicole.steils@kcl.ac.uk; Social Care Workforce Research Unit, King’s College London, Strand, London, WC2R 2LS.

**What if something goes wrong in the research?**

If you feel that this study has harmed you in any way, you can contact Professor Keith Brennan using the following details for further advice and information: Professor Keith Brennan: keith.brennan@kcl.ac.uk; 020 7848 6391 / 020 7848 6391 (for PA, Sandra Dickson); King’s College London, Strand, London, WC2R 2LS.
Organisation and allocation of AMHP work

Please state your role in the organisation:

What responsibility do you have for managing the AMHP service in the area?

Do you have AMHPs whose sole role is as an AMHP?

- Yes
- No

Please comment on your answer:
Local Authority or Mental Health NHS Trust: organisation and allocation of AMHP work

In your area, are mental health teams, in which AMHPs work, under the direct control of Local Authority or the Mental Health NHS Trust?

Please choose one answer and you will be forwarded to the appropriate questions. 

*Required*

- Local Authority
- Mental Health NHS Trust
Local Authority: organisation and allocation of AMHP work

Have the mental health social work teams, in which AMHPs work, returned to Local Authority control in the last three years?

☐ Yes
☐ No

If you have answered Yes, please comment on the reasons for this change:

What difference do you think this has made to the recruitment and retention of AMHPs who are not social workers?

☐ Made it easier to recruit
☐ Made no difference
☐ Made it more difficult to recruit

Please comment on your answer:
Are there plans to integrate mental health social care and NHS services?

- Yes
- No
- Don’t know

Please comment on your answer:

What difference do you think this will make to the recruitment and retention of AMHPs who are not social workers?

- Will make it easier to recruit
- Will make no difference
- Will make it more difficult to recruit

Please comment on your answer:
Mental Health NHS Trust: Organisation and allocation of AMHP work

When did mental health social care and NHS services integrate in your area?

What difference did this make to the recruitment and retention of AMHPs who are not social workers?

☐ Made it easier to recruit
☐ Made no difference
☐ Made it more difficult to recruit

Please comment on your answer:

Are there plans to return the mental health social work teams, in which AMHPs work, to Local Authority control?

☐ Yes
☐ No
☐ Don't know
☐
If you answered Yes, please comment on the reasons for this intended change:

What difference do you think this would make to the recruitment and retention of AMHPs who are not social workers?

- Would make it easier to recruit
- Would make no difference
- Would make it more difficult to recruit

Please comment on your answer:
Supply of Approved Mental Health Professionals

How many AMHPs have you got in your Local Authority/Mental Health NHS Trust?

Is this number sufficient?

☐ Yes  ☐ No

Please comment on your answer:

How do you identify the need for AMHPs?

What is the split between day time AMHPs and out of hours AMHPs (eg. Emergency Duty Team)?
<table>
<thead>
<tr>
<th>Role</th>
<th>Please give numbers or per cent:</th>
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</thead>
<tbody>
<tr>
<td>Social Workers</td>
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<tr>
<td>Mental Health and Learning Disability Nurses</td>
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<tr>
<td>Chartered Psychologists</td>
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<tr>
<td>Occupational Therapists</td>
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</table>

Please comment on your answer:

How many AMHPs have left your service in the last 3 years?

How many AMHPs in your Local Authority/Mental Health NHS Trust are:
How easy or difficult is it to enable eligible health professionals to become AMHPs?

Please don't select more than 1 answer(s) per row.

<table>
<thead>
<tr>
<th></th>
<th>Very easy</th>
<th>Easy</th>
<th>Difficult</th>
<th>Very difficult</th>
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<tbody>
<tr>
<td>Mental Health and Learning Disability Nurses</td>
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<td>Chartered Psychologists</td>
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<tr>
<td>Occupational Therapists</td>
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</table>

Please comment on your answer:

What would make it easier (or possible) to enable these professionals to become AMHPs?

Please comment:

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<th>Please comment:</th>
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<tbody>
<tr>
<td>Mental Health and Learning Disability Nurses</td>
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</table>
Please comment on your answer:

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<tr>
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<tr>
<td>Occupational Therapists</td>
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</table>

What makes it more difficult for the other professionals to become AMHPs? Please specify any particular difficulties for the different professions:

How important (if at all) are rates of pay in encouraging or discouraging health professionals to become an AMHP?

Very important
Important
Moderately important
Important
Please comment on the role played by pay in encouraging or discouraging health professionals to become an AMHP?

At what NHS Band should any fully time AMHPs be paid?

In your view should AMHPs be paid more than their usual salary if they undertake the work...

Please don’t select more than 1 answer(s) per row.

in addition to their usual job?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
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</table>

One increment above their current NHS Band per annum
Two increments above their current NHS Band per annum
Standard amount per assessment
If you answered Yes to 'as part of their usual job', how much more should AMHPs be paid?

If you answered Standard amount per assessment or Other, please specify:

- One increment above their current NHS Band per MHA assessment
- Two increments above their current NHS Band per MHA assessment
- Standard amount per assessment
- Other

If you answered Yes to 'in addition to their usual job', how much more should AMHPs be paid?

If you answered Standard amount per assessment or Other, please specify:
Training

How long is the AMHP training in your area?

Is this full- or part-time?

- Full-time
- Part-time
- Either
- Other

If you answered Other, please specify:

Is the training accessible to Mental Health and Learning Disability Nurses, Chartered Psychologists and Occupational Therapists?

Please don't select more than 1 answer(s) per row.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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<tr>
<td>Mental Health and Learning Disability Nurses</td>
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<td>Occupational Therapists</td>
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</table>
Please comment on your answer:

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How much backfill is available for the duration of the training course?

Please don’t select more than 1 answer(s) per row.

<table>
<thead>
<tr>
<th></th>
<th>Full</th>
<th>Partial</th>
<th>None</th>
<th>Don't know</th>
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<tr>
<td>Mental Health and Learning Disability Nurses</td>
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<tr>
<td>Occupational Therapists</td>
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Please comment on your answer:

---

How many people can access AMHP training each year?

---
How many people have you trained in the last 3 years?

Who funds the training?

What is your opinion of the local training for AMHPs?

Policies

Are there policies aimed at increasing the proportion of AMHPs who are not social workers in the Local Authority/Mental Health NHS Trust? Please describe:

What (if any) policies or future plans to improve retention of AMHPs are there in the Local Authority/Mental Health NHS Trust? Please describe:
Views about the kinds of professionals who should work as AMHPs

What (if any) are the advantages of having other professionals working as AMHPs. Please specify any particular advantages for the different professions:

<table>
<thead>
<tr>
<th>Professional</th>
<th>Please comment:</th>
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</thead>
<tbody>
<tr>
<td>Mental Health and Learning Disability Nurses</td>
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<tr>
<td>Chartered Psychologists</td>
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<tr>
<td>Occupational Therapists</td>
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</tbody>
</table>

What (if any) are the disadvantages of having Mental Health or Learning Disability Nurses; Chartered Psychologists or Occupational Therapists as well as social workers acting as AMHPs?

<table>
<thead>
<tr>
<th>Professional</th>
<th>Please comment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Learning Disability Nurses</td>
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<tr>
<td>Occupational Therapists</td>
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</tbody>
</table>
Do you think other professionals from other backgrounds (e.g. psychiatrists) should be allowed to become AMHPs?

- Yes
- No

If you answered Yes, which other professions and why:

If you answered No, why not?
Additional comments and finish

Have you got any other comments?

Dear participant,

Many thanks for participating in and giving your time completing our survey.

Below you will find the 'Finish' button. Once you click the button, you will not be able to make changes to the survey and your answers will be submitted to the research team.

Thank you

Your answers have been submitted to the research team and you can close the website.

Thank you for participating in the survey.
Appendix 2: Interview guide – AMHPs who are nurses/psychologists/OTs

IRAS Project ID: 230177

Professional background
1. What is your primary professional background?

2. How long ago did you qualify as a Nurse, Psychologist/OT?
   a. And when did you qualify as an AMHP?

Motivations
3. What motivated you to train as an AMHP?
   a. How long ago was this?
   b. How long had you been qualified before you decided to become an AMHP?
   c. Were there any expectations from your managers that you become an AMHP? – Please describe.
   d. How did your managers respond when you decided to become an AMHP?
      i. Supportive – why and how?
      ii. Opposed to the idea – How and why?
      iii. Who funded the training?
      iv. Was there backfill while youdid the AMHP training? (and if yes who paid?)

2. Please would you describe your training?
   a. Did you find your training sufficient?

4. What keeps you motivated to work as an AMHP?
   a. Aspects of the work
   b. Fit with the other aspects of your work

5. What part did financial remuneration play in your motivation to work as an AMHP?

6. What would be a reasonable rate of remuneration for AMHP work?

7. Are you planning to continue working as an AMHP?
   a. Why/why not? (Banding/on-call costs)

8. What part does the financial remuneration play in your decision to continue working as an AMHP?

9. Are you a member of a union?
   a. If yes, what (if any) impact has the union had on your decisions about being an AMHP?

Role
10. What do you believe are the most important aspects of the AMHP role?
11. What do you enjoy about AMHP practice?
   a. Time limited nature of the work?
   b. Crisis resolution?
   c. And what about any extra money or working arrangements eg Time off, car, etc
   d. Anything else?

12. What do you find difficult about carrying out your AMHP role?
   a. Do you work as an AMHP with people on your own caseload (or is this avoided – why?)
   b. Is there any impact on your relationships with any other service users you work with?
   c. Is your AMHP a ‘stand alone’ role?
   d. What updating do you get about the AMHP role eg in law?

13. Are there any conflicts in your role?

14. What do you think helps good AMHP practice?
   a. What, if anything, about your professional background helps good AMHP practice?

15. What do you think hinders good AMHP practice?
   a. What, if anything, about your professional background hinders good AMHP practice?

Working as an AMHP
16. How do you balance your role as an AMHP with your other work?

17. Are there any external factors that are affecting your experience of the work?

18. Do you receive supervision as an AMHP?
   a. Who provides supervision?
   b. How often do you receive supervision for your AMHP work?
   c. Please comment on the nature and quality of the supervision

19. Do you feel valued and supported by professional colleagues, other colleagues, and management?
   a. How, if at all, has working as an AMHP affected your relationships with your colleagues?
   b. How, if at all, has working as an AMHP affected your relationships with your manager?

Who should be able to work as an AMHP?
20. What are your views on AMHP training being open to mental health/learning disability nurses, occupational therapists and psychologists besides social workers?
21. Should other professionals be able to train as an AMHP? (eg prompt if needed – a psychiatrist? An experienced Mental Health support worker?)
   a. Why?/why not?
   b. If yes, which other professionals?
22. Have you any other comments about working as an AMHP or views on its role?
Appendix 3: Interview guide – professionals who are not AMHPs

IRAS Project ID: 230177

1. What is your primary professional background?

2. When did you qualify and register as a mental health or learning disability nurse/psychologist/OT?

3. Have you considered becoming an AMHP?
   a. Have you had a conversation with anyone about becoming an AMHP? Please outline
   b. Have you decided not to become an AMHP? – Why?
   c. Are you planning to train as an AMHP? – Why?

4. What role does the level of remuneration play in encouraging or discouraging you to become an AMHP?

5. What would be a reasonable rate of remuneration for AMHP work?

6. Are you a member of a union?
   a. If yes, what (if any) impact has the union had on your decision about becoming an AMHP?

7. Are any of your colleagues who are mental health or learning disability nurses, psychologists or occupational therapists AMHPs?
   d. How, if at all, has this affected your relationship with them?
   e. Do you or others ask them for any advice or similar eg on law or about referrals for Mental Health Act assessments?

8. What do you believe are the most important aspects of the AMHP role?

9. What do you think hinders good AMHP practice?

10. What (if any) are the advantages of having mental health and learning disability nurses; psychologists; or occupational therapists act as AMHPs besides social workers?

11. What (if any) are the disadvantages of having mental health and learning disability nurses; psychologists; or occupational therapists as well as social workers act as AMHPs?

12. Do you think other professionals from other backgrounds (e.g. psychiatrists or police or experienced support workers) should be permitted to become AMHPs?
   a. If yes, which other professions?
   b. Why/Why not?

13. Have you any other comments?
Appendix 4: Interview guide – AMHP Leads

IRAS Project ID: 230177

1. Please describe how mental health services are organised in your /LA
   a. Integrated mental health service
   b. Non-integrated service
   c. Who work as AMHPs?

2. How does this affect management and support of AMHPs?
   a. Trust or LA managers?

3. How are Mental Health Act assessments allocated?

4. How easy or difficult is it to recruit AMHPs?
   a. Why do you think it is as easy/difficult?

5. Please describe the training given to AMHPs in this LA

6. Have you got any policies to improve retention of AMHPs? (Please describe)

7. Have you got any plans to improve retention of AMHPs?

8. What role does the level of remuneration play in encouraging or discouraging health professionals to become an AMHP?

9. What would be a reasonable rate of remuneration for AMHP work?

10. What (if any) impact have trade unions had on health professionals’ decisions about being an AMHP?

11. What (if any) are the advantages of having mental health / learning disability nurses; psychologists; or occupational therapists act as AMHPs?

12. What (if any) are the disadvantages of having mental health / learning disability nurses; psychologists; or occupational therapists as well as social workers act as AMHPs?

13. What is your professional role?
   a. Do you think this has implications for your answers? (please describe)

14. Have you got any other comments?
Appendix 5: Interview guide – Other professionals

IRAS Project ID: 230177

1. When you are involved in a MHA assessment, are you usually aware of the professional background of the AMHP?

2. Have you noticed any difference made by the professional background (social workers; mental health or learning disability nurses; psychologists; occupational therapists) of AMHPs in respect of:
   a. Practice of the AMHP?
   b. Interactions between the AMHP and other professionals?
   c. Consideration of the social aspects of the case?

3. What (if any) are the advantages of having mental health or learning disability nurses; psychologists; or occupational therapists act as AMHPs?

4. What (if any) are the disadvantages of having mental health or learning disability nurses; psychologists; or occupational therapists as well as social workers act as AMHPs?

5. What in your opinion would encourage mental health or learning disability nurses; psychologists; occupational therapists to become AMHPs?
   a. Aspects of the work
   b. Fit with the other aspects of your work
   c. Financial remuneration
   d. What would be a reasonable rate of remuneration for AMHP work?
   e. Anything else?

6. What in your opinion would discourage mental health or learning disability nurses; psychologists; occupational therapists from becoming AMHPs?
   a. Aspects of the work
   b. Fit with the other aspects of your work
   c. Financial remuneration
   d. Anything else?

7. Do you think other professionals from other backgrounds (e.g. psychiatrists) should be allowed to become AMHPs?
   a. If yes, which other professions?
   b. Why/Why not?

8. Do you think your professional role has implications for your answers?

9. Have you any other comments?
Appendix 6: Interview guide: people (and their families) with experience of being assessed by an AMHP

IRAS Project ID: 230177

The interviewer will explain the term assessment and AMHP at each question, using terms that the participant has used or understands.

1. When you had your assessment (explain - when you were or could have been ‘sectioned’ or detained) were you aware that one of the professionals (not a doctor or the police) has the role of an ‘Approved Mental Health Professional’, sometimes called an AMHP?

   If the participant doesn’t know, mention these aspects
   a. This professional will have organised the assessment (meeting)
   b. This is the professional who will have told you about the decision about being sectioned/detained or not
   c. This professional will have stayed with you after the meeting and may have gone with you to hospital (if relevant)

2. Had you met this professional before the assessment?
   If yes
   a. In what capacity did you know the professional?
   b. What was it like having someone you know do the assessment?

   If no
   c. What was it like having a stranger do the assessment?

3. How well did this professional manage the assessment?
   Explore whether the professional:
   a. Appeared to understand how the participant was feeling?
   b. Do you feel they listened to you?
   c. Were they clear about what was going to happen at the meeting and afterwards?
   d. Did they explaining the different possible decisions and how they were going to be reached?

4. Do you know what job the AMHP (explain if necessary) usually did/worked as?

   AMHPs can be social workers, mental health or learning disability nurses, psychologists or occupational therapists.

5. Do you have any views or opinions about professionals working as AMHPs who are....
   a. Mental health or learning disability nurses
   b. Psychologists
   c. Occupational Therapists?
6. What do you think might motivate these professionals to become AMHPs?

7. What do you think might discourage these professionals from becoming an AMHP?

8. Do you think other professionals from other backgrounds (e.g. psychiatrists, police, experienced mental health support workers) should be allowed to become AMHPs?
   a If yes, which other professions?
   b Why/Why not?

9. Have you ever been invited to take part in any training or learning for AMHPs or other mental health professionals? If yes, please outline

10. Have you any other comments?