National Workforce Plan for Approved Mental Health Professionals (AMHPs)

Contents

Executive summary

The National Workforce Plan for Approved Mental Health Professionals (AMHPs) is written for local authorities, directors of adult and children's social care, NHS Mental Health Trusts (MH Trusts) and Integrated Care System workforce leads to understand the role of the AMHP in mental health services, to coordinate the development of the AMHP role and the recruitment and retention of AMHPs in their area.

The AMHP role is one of the most important in mental health. It is integral to the core services of both local authorities and NHS Trusts, and has an impact on acute NHS Trusts, ambulance services and the police. There is evidence, however, that it has not been given the full support, recognition, review and structure that it requires in order to be completely effective [The Association of Directors of Adult Social Services (ADASS), 2018; Care Quality Commission (CQC), 2018; King's College London (KCL), 2018; Stevens *et al.,* 2018a]. The document is a resource for agencies wishing to develop their AMHP services, where the latest information about the AMHP role is held in one place.

This document consists of three parts:

1. The **resource** section, which describes the role of the AMHP and the current national standards, regulations, research and developments affecting the role.

2. The **National Workforce Plan for AMHPs**, which looks at the employment, recruitment and retention of AMHPs. It has been developed so it can be separated off for inclusion in other national or regional workforce plans and publications, and

3. An appendix containing the **AMHP service standards**, which are a key part of this workforce plan and will underpin the future development of the AMHP role.

The National Workforce Plan for AMHPs is designed to assist Social Work England (SWE) as it takes responsibility for AMHP training and standards. SWE have been involved in its development. It is useful for the Department of Health and Social Care (DHSC) team developing the new Mental Health Act (MHA) and accompanying regulations. It is designed to assist in the development of national and regional workforce plans, such as the Social Care green paper or the NHS Long Term Plan, where Health Education England have been important partners in its development.

This document has been subject to considerable consultation and development with AMHPs and national agencies and will be updated to reflect the changing role of the AMHP, and the national legal and policy frameworks.

This plan is only relevant to England; we recommend the development of a similar AMHP workforce plan for Wales that aligns to this document.

Information and background

Introduction

The AMHP is a statutory role created with the enactment of the MHA 2007, replacing the Approved Social Worker (ASW) of the MHA 1983. Eligible professionals undertake the AMHP role on behalf of local authority social services departments, who are legally responsible for the AMHP service. The role is also closely linked to NHS MH Trusts, who provide many of the services that AMHPs require to undertake their role. AMHPs work in very close partnership with the NHS.

The AMHP has a responsibility to organise and undertake an assessment under the MHA 1983 and, if the legal definitions are met, to authorise detention under the Act. AMHPs have specific responsibilities to uphold the human rights of people assessed under the Act, consider the social perspective and follow the guiding principles of the MHA, which includes applying the least restrictive principle. The AMHP is also responsible for organising the complex inter-agency arrangements required to undertake the assessment and communicating with everyone involved, including the person's Nearest Relative (NR).

Recent research publications have shown that the AMHP role is under a great deal of pressure for multiple reasons. In some areas, it is increasingly hard to provide the statutory service prescribed by the MHA and the revised (2015) Code of Practice [Department of Health (DoH), 2014; 2015; CQC, 2018]. This can include delays for assessments, an inability to find an appropriate bed for someone detained under the MHA or a lack of community alternatives. The pressures within the AMHP service and especially within the wider services can mean that people in mental health crisis do not always receive the service quality they should expect (DHSC, 2018). These pressures also affect staff morale, recruitment and retention. The AMHP service also has demographic pressures that are adding to these issues (Skills for Care, 2018).

There are opportunities to reform and resolve these issues. The MHA has recently been reviewed by the government and the regulation of approved educational programmes to train AMHPs is passing to Social Work England from the Health Care Professions Council (HCPC). Workforce issues are a major part of the Health Education England (HEE) mental health workforce plan and will be included in the NHS Long Term Plan and Green Paper for Social Care. We have an opportunity to undertake a review of the AMHP service, its training and structure with the development of Social Work England.

The purpose of this paper is to outline the national drivers affecting the AMHP role, identify the workforce requirements and provide a structure that can be used to consolidate, stabilise and support AMHPs.

Background – the role of the AMHP

AMHPs have a key statutory role in the effective delivery of mental health services:

- AMHPs lead the organisation of statutory mental health assessments under the MHA 1983. They are responsible for organising the assessment, the identification of the Nearest Relative and organising doctors and key agencies, such as police and ambulance. AMHPs are independently responsible for a decision to detain a person and arrange conveyance to hospital.

- AMHPs have a key responsibility to ensure that people's human rights are upheld and that the guiding principles of the MHA, as laid out in its Code of Practice (2015), are followed. They ensure that the most appropriate legal framework is selected in line with current case law interpretation, whilst the guiding principle of ensuring least restrictive decision making remains at the forefront of this process.

- AMHPs have other duties and powers under the MHA in relation to community treatment orders, guardianship, applying to court to displace a NR or taking over the NR role and applying to court for warrants under section 135 of the MHA.

- AMHPs work within complex organisational systems and it is widely recognised that AMHPs operate most effectively within a 'whole-systems' approach where NHS, local authorities, police and other agencies work together (CQC, 2018).

AMHPs are approved or authorised by local authorities. Historically, the role has been undertaken by social workers (prior to the 2007 amendments, the role was known as the Approved Social Worker). Since 2007, mental health and learning disabilities nurses, occupational therapists and chartered psychologists have been able to train to be AMHPs, but currently social workers still occupy 95% of the AMHP role.

Training is undertaken by universities at a master's level. The qualification is a delivered as a post-graduate certificate, post-graduate diploma or full MSc/MA (depending upon the local arrangements. All are regulated by the HCPC, but this will be taken over by Social Work England in 2020. Most courses involve a placement - with a mixture of academic work, assessed experience and a portfolio. The length of the course can be varied as long as the academic and practice components are met.

The AMHP role is crucial to ensure that the rights of people in mental health crisis are protected, that detention is avoided whenever possible, that social issues are considered and that the views of people and families are included in assessments under the MHA.

The original ASW role was developed to be completely independent from the health service and designed to protect peoples' rights within a social model of mental health provision. The government at that time *accepted MIND's and British Association of Social*

Workers (BASW) argument that, in the absence of judicial scrutiny, the exercise of medical power should be moderated by an independent social worker' (Hargreaves, 2000). The development of integrated multi-disciplinary teams has influenced this remit; current evidence suggests that AMHPs from social work and nursing backgrounds make similar decisions around risk (Stone, 2018). Furthermore, the role still has human rights and a social approach at its heart – regardless of the profession undertaking the role. This is supported by research identifying that considerations about human rights are dominant within AMHP decision-making (Buckland, 2014; Dixon *et al.,* 2018; Laing *et al.,* 2018).

Background – national developments that affect the AMHP role

National developments that may directly or indirectly affect the role of the AMHP include:

- The **review of the MHA 1983** published its final recommendations on 6 December 2018 (DHSC, 2018). There are a number of recommendations that will directly affect or expand the AMHP role. In addition, the recommendations will affect the services in which AMHPs operate – especially in relation to crisis and home-treatment teams, acute care and community alternatives to admission.

- An **All-Party Parliamentary Group (APPG) on Mental Health Social Work** (BASW, 2019) met in June and July 2019 and produced a report on the implications of the MHA review for mental health social work and AMHPs. The report was published in late July 2019 and contained the following recommendations that are relevant here:

  - New mental health legislation should open with a definition of the social model and importance of the social determinants of mental illness … explicitly naming social workers as the key professionals doing this work.

  - Ministers should ensure that new mental health legislation also produces guidance on how it is intended to interact with the Mental Capacity Act, the Care Act, the Human Rights Act, the Equality Act and the Children Act.

  - Mental health legislation must have regard to health and local authority resources to ensure compliance with legislation and human rights, including ensuring that local areas have a minimum number of AMHPs.

  - CQC should be mandated to provide an annual report to Parliament on the progress of health and social care integration [between local authorities and] Trusts, as well as between children's services and children's mental health services. This should include input from both the Chief Social Workers.

- Social work leadership on Trust and Clinical Commissioning Group (CCG) boards is necessary to ensure integrated approaches overall including crisis responses when people may be subject to the MHA e.g. reducing and better managing use of section 136, provision of age appropriate places of safety, holistic assessment of people in crisis and provision of alternatives to admission.

- CCGs should be held transparently accountable for their duties under section 140 (s140) of the MHA, making sure that there are enough beds, enough children and young people's beds and that AMHPs know where they are.

- A national data set on the number of MHA assessments (not just admissions), their outcomes, the age of the people assessed, ethnicity and discharge rates should be established by NHS Digital and Skills for Care.

- The **Community Mental Health Framework** has been developed by the **National Collaborative Centre for Mental Health**, having been commissioned by **NHS England and the National Institute for Health and Care Excellence (NICE).** This is a framework for community mental health services designed to operate across primary and secondary NHS services, social care and housing within a preventative, asset-based and recovery-led model. This will influence the way that AMHPs work – especially in community services for adults and older people. It is hoped that investment in integrated community-based mental health services may reduce the number of detentions.

- The **NHS Long Term Plan** was published in January 2019 (NHS England, 2019) and has a substantial number of recommendations for mental health services, including crisis, community and acute services. There is likely to be a renewed emphasis on partnership with local authorities and social care. The NHS England Adult Mental Health (AMH) team recognise the importance of the AMHP role in these plans.

- The **Green Paper for Social Care** is an ongoing consultation process by **DHSC** that will eventually set out a vision for adult social care based on a more personalised approach that keeps people at home and in their community. It will include workforce issues that will eventually influence the AMHP role.

- The **Green Paper for Prevention** is a consultation process by **DHSC** published in July 2019. It looks at the role of the NHS, public health and social care in that encourages positive healthy communities and prevents future health issues. Mental health and the social determinants of health runs through this and supporting people to reduce crisis is at the heart of the process.

- The **Mental Health Workforce Plan** is led by **HEE** and **NHS Improvement** and is part of a workforce plan for health and social care. The AMHP workforce plan will be part of this strategy. This covers recruitment and retention and new roles for the future mental

health service. This plan is focussed on the needs of the NHS Long-Term Plan; therefore, we will be working closely to link the local authorities and Skills for Care to ensure the local authority viewpoint is represented.

- The new regulator for social work, **Social Work England**, will also regulate all AMHP courses and the social work staff authorised as AMHPs. Social Work England is currently in discussion with other regulators for professionals undertaking the AMHP role to try to ensure consistency of approach for nurses, occupational therapists and chartered psychologists. Social Work England is currently developing the legal and regulatory framework to transfer these responsibilities from the HCPC and so will have a key role in implementing this AMHP workforce plan from December 2019.

- A new set of **AMHP service standards** has been produced (see Appendix One) that provides an agreed operating model for local authorities and their partners in developing and delivering AMHP services. A recommendation of this workforce plan is that these standards should be incorporated into AMHP regulations and training and underpin AMHP services as a consistent approach across the country.

- The **Local Government Association (LGA) guidance for employers of social workers** is currently being reviewed by the LGA and a group of experts. This document will, when published later in 2019, be a very important tool to support the implementation of this AMHP workforce plan and will be backed up by guidance form HEE to support NHS MH Trusts who also employ social workers or AMHPs.

- **CQC** published its briefing: **Mental Health Act – Approved Mental Health Professionals** in March 2018 (CQC, 2018). The briefing outlined CQC's research and consultation with 12 AMHP services within local authorities and MH Trusts and made a number of helpful observations and recommendations.

- The **Mental Health Core Skills Education and Training Framework** was published by **Skills for Care, Skills for Health** and **HEE** (2016). This document outlines the expected knowledge and skills required by all mental health professionals and was written to cover the health and social care workforce, with many recommendations that are relevant for AMHPs.

- In 2017, the **National Collaborative Centre for Mental Health** completed its expert reference group on mental health staffing issues. This was known as **ESCASS – effective, safe, compassionate and sustainable staffing**. This made recommendations about workforce planning relevant to the AMHP and social care workforce. An integrated workforce calculator was developed, incorporating a competence, needs-based approach useful for AMHP workforce planning.

- In 2017, **HEE** produced '**Stepping forward to 2020/21: The mental health workforce plan for England**' (HEE, 2017). This consultation and planning document

laid out a workforce plan for mental health services that was designed to support the Five Year Forward View. This document did not include social work and social care; however, it did recognise that '*To deliver this growth and transformation agenda, we will need motivated and multi-professional teams focussed on delivering person-centred care'* and that social work and social care staff would have a key role in this and in the new roles planned.

Background – recruitment and retention issues for AMHPs

Recent national research (ADASS, 2018; CQC, 2018; KCL, 2018; NHS Benchmarking and ADASS, 2018, Stone, 2019) has identified growing recruitment and retention issues in the AMHP workforce and a need for improved workforce planning nationally and regionally.

In April 2018, the results of a **snapshot survey** on the data and status of mental health social work and AMHPs was published jointly by NHS Benchmarking and ADASS (2018). This found that there were around **3,250 AMHPs** authorised by local authorities in England, but that the numbers of whole-time equivalent AMHPs varied from two to nearly 80, with a national average of 20 per region. This means there are six AMHPs per 100,000 population. This was a 17% drop in AMHP numbers from the last survey in 2009, whilst the number of assessments and detentions under the MHA has risen to a total of **142,000** assessments undertaken in 2016-17 with over 45,000 leading to detention.

In December 2018, Skills for Care published its first annual report on the AMHP workforce, following an amendment to the National Minimum Data Set for Social Care (NMDS-SC) (replaced by the new Adult Social Care (ASC) Workforce Data Set service in August 2019 (Skills for Care, 2018). This found that there were **3,900** AMHPs in England, but that only **3,400** were currently practising. The report concluded that *'Overall, AMHPs are more likely to be male, older and white than the social work workforce. Data from the NMDS-SC shows that while 21% of social workers are aged 55 or over, this rises to 30% (almost in 1 in 3) when we look at just AMHPs. With regard to gender, overall, 19% of social workers are male, this rises to 29% when only considering AMHPs. Lastly, 77% of all social workers are white, this rises to 85% for AMHPs.'* (Skills for Care, 2019).

In 1991, the Social Care Inspectorate recommended a ratio of between 1:7,600 (inner city) and 1:11,800 (other) approved staff (AMHP) to population (dependent on locality). In November 2017, the average was 1:16,000 (NHS Benchmarking and ADASS, 2018). As the numbers of assessments have increased, the numbers of AMHPs have decreased. According to these figures, an inner-city area of 250,000 population should have 33 full-time equivalent daytime AMHPs, and a shire county with a population of 1.1 million would need 100 full-time equivalent AMHPs. These figures are very out-of-date, and the evidence base for this population-based planning is weak and untested.

AMHPs are approved to work in a designated geographical area. This reduces the flexibility in deployment of AMHPs and is challenging to staff in rural areas, especially out of hours. Some areas have private hospitals that bring in individuals from a much wider geographical area but create a responsibility for the local AMHP service. Cross-boundary issues are also an influence, as are the specific working arrangements of local NHS Trusts and the quality of relationships across agencies (CQC, 2018).

In 2017, NHS Benchmarking undertook a survey of AMHPs and social work in mental health in partnership with ADASS (NHS Benchmarking and ADASS, 2018). Across England, 86% of AMHPs were reported to work within adult mental health and 7% within older adult services. 3% of AMHPs sat within children's services and 4% within learning disabilities. The survey found that 95% of AMHPs were social workers, with the remaining 5% being nurses and a small number of occupational therapists. One chartered psychologist was found to be undertaking the role. The Stevens *et al.* report (2018b) on why the numbers of non-social work AMHPs remains so low is outlined below.

The **APPG on Social Work** looked in detail at mental health in 2016 (BASW, 2016a) and its report stated *'Social workers fulfil a vital role in protecting people's rights when they are in crisis or where a situation has deteriorated – particularly through their work in safeguarding, as AMHPs and Best Interests Assessors (BIAs). These crucial roles are often low profile and a lack of workforce planning for AMHPs was evident in the inquiry.'*

This APPG reviewed this in 2019 (see page 6) and came to similar conclusions, with a recommendation for a cross-departmental AMHP workforce plan (BASW, 2019).

The **Social Work for Better Mental Health** programme has been working with over 60 local authorities and MH Trusts across the country to consider best practice in the support and development of social workers and to evolve new approaches to multi-disciplinary team work, continuous professional development (CPD) and progression pathways for mental health social workers. A national 'community of practice' is being established to improve the visibility of the social model and the sustainability of the AMHP role. The workforce needs of AMHPs were made clear in its 2016 guidance:

'Despite the vital importance of this role, there have been research reports and professional surveys demonstrating that the AMHP service in England is under stress – both in terms of sustainable numbers of staff and quality of working conditions for AMHPs. Studies have shown they often feel exposed to violence and aggression, expending large amounts of emotional labour coordinating complex and risky situations supporting service users and their families while they wait for other professionals to mobilise support and resources – such as providing beds or ambulance conveyance.

Addressing this needs consistent and well-supported professional leadership, better workforce planning and attention to the organisational context of practice. This needs to come from within social work, because of the social model underpinning AMHP training

and ethos, and because the responsibility of the AMHP service rests squarely with the local authority as an independent body' (Allen *et al.,* 2016).

The **CQC briefing on AMHPs** was published in March 2018 (CQC, 2018). This report was helpful in using a study of 12 areas to check the health of the AMHP systems and workforce. The following issues were identified:

- There are increasing problems in the recruitment and retention of AMHPs.

- The AMHP role is often not attractive to nurses, occupational therapists and psychologists due to personal, cultural and structural reasons (Stevens *et al.,* 2018a; Stone, 2019).

- There is lack of national job descriptions, standards or registers of AMHPs.

- There is a lack of data on AMHPs and their activity and performance.

- There are substantial ongoing pressures upon the AMHP role – especially bed issues, workload, complexity and the effect of austerity and social issues – which are outside of the remit of the AMHP or their employer and approving organisation.

ADASS published its **'Top Tips for Directors'** on the recruitment and retention of AMHPs in each region and the practice data needed for their employment in 2018 (ADASS, 2018). The main points are summarised below:

- The Director of Adult Social Services (DASS) must assure themselves that the AMHPs they authorise are competent to practice. The DASS role should include:

  - overseeing the approval and authorisation processes,

  - keeping a list of AMHPs who have been approved and authorised,

  - recording the 18 hours of annual AMHP-specific training,

  - ensuring that guardianship approval under the MHA is appropriate, and

  - ensuring that AMHPs have access to independent legal advice, and vicarious liability insurance.

- The MHA regulations ensure that local authorities must have enough AMHPs available to provide a 24/7 service. This is best planned as part of a whole-system workforce plan that includes Sustainable and Transformation Partnerships (STPs).

- The stresses on AMHPs often relates to the availability of resources, including transport, lack of beds, rising numbers of assessments and police resources. Monitoring these issues and developing whole-system responses is important.

- AMHP morale and work-stress issues should be monitored as part of workforce planning with partners at a strategic level – usually health and wellbeing boards.

- DASS's should understand the local AMHP staff profile and monitor retention:

    - DASS's should plan for training and workforce needs, including the post-qualifying experience needed to train as an AMHP.

    - Local authorities should pay extra for the role and out-of-hours working.

    - AMHPs should be supported to stay on and train the next generation.

    - AMHPs should be trained across all areas of mental health.

    - DASS's should have an AMHP lead and Principal Social Worker to oversee the AMHP role and report directly to the DASS. AMHPs based in NHS Trusts need to be able to access this support.

    - AMHPs need support and supervision in line with regulations.

There have now been two studies (Stevens *et al.,* 2018a, Stone, 2019) that have looked at why other professionals who are not social workers may not want to train as AMHPs or may not be supported to do so. **KCL** found that:

- Reductions in integrated teams makes it more isolating for professions.

- Salary differences between health and social care make the role less attractive.

- There is a perceived lack of understanding or support for the role by NHS Trusts.

- There is a lack of resources for backfilling MH professionals when on the course.

- There is a perceived lack of support for 'health' AMHPs by some local authorities.

- There are cultural issues between health and social care that nurses and occupational therapists may struggle with.

The **KCL** team made the following recommendations:

- Create a joint responsibility for AMHPs across local authorities and Trusts (local authorities must have the legal responsibility, so this would be a local agreement).

- Create specific responsibilities for enabling health professionals to access training and ensure that local authorities, NHS Trusts or Integrated Care Organisations (ICOs) support them.

- Make a national decision about a consistent approach to the amount to pay AMHPs and consider providing enhanced payments for all health and social care professionals acting as AMHPs, similar to the enhancements linked to becoming a nurse prescriber or a 'section 12 (s12)' (approved) doctor to create parity.

- Professional bodies and regulators, such as the Royal Colleges of Nursing or Occupational Therapists, should be involved in encouraging health professionals to become AMHPs, working with Social Work England.

- Integrated management and co-location of AMHP services are the best way of improving the numbers of health professionals becoming AMHPs.

The recommendations made by KCL are supported by the Stone (2019) study that looked specifically as to why nurses do not take up the role. That study found that:

- Structurally, nurses found accessing and applying for AMHP training very difficult.

- Agreeing contractual terms and comparative pay was challenging for nurses.

- Balancing their AMHP and nursing role can create conflicts with employers.

KCL also published an addendum to this report: **Recruiting and retaining social worker AMHPs: evidence and research agenda** (Stevens *et al.,* 2018b). This found that there was a high level of stress and emotional exhaustion among AMHPs, with various issues affecting AMHP retention:

- Undertaking MHA assessments is a complex activity that can be very stressful.

- Finding a hospital bed for detained people is identified as the most problematic practical aspects of undertaking an MHA assessment; however, this is not actually the role of the AMHP within the MHA Code of Practice (2015).

- The study identified that difficulties accessing s12 (approved) doctors, and liaising with the police and ambulance services, contributed to AMHP stress, including uncertainty about working hours and personal safety.

The **College of Social Work published a report on the role of the Mental Health Social Worker** in 2014 that specifically identified the **leadership of the AMHP** role as a core responsibility of local authorities, working in partnership with local and regional NHS leads (Allen, 2014). This document identified the following as key to workforce planning:

- An identified service manager should ensure the availability of AMHP professional and legal advice, supervision and development programmes.

- There should be workforce management and succession planning to ensure ongoing sufficiency of AMHPs.

- Forums whereby systemic issues affecting AMHP practice can be resolved, e.g. workload and relationships with partners, such as the police and ambulance.

- Improved AMHP data should inform best practice and improvement at a local level.

- The local authority should be involved at a senior level in local strategic, multi-agency planning for mental health services, e.g. STPs/ICOs.

The AMHP workforce – a summary of the current challenges by Karen Linde (Social Work for Better Mental Health)

Recent reports (see footnote 1) highlight widespread shortfalls in the number of AMHPs recruited and increasing difficulties in retention in the context of growing demand. The AMHP Leads Network undertook national surveys in 2013 and 2016, finding increases in prevalence of several key difficulties related to the completion of MHA assessments.

Whilst multiple factors have been identified, such as changing workforce demographics, role conflict and workplace stress, there has been a marked association of growing difficulties with the AMHP role and the wider intensifying of resources and organisational pressures in the NHS and social care. This is especially related to access to beds, the availability of alternatives to admissions and the functioning of crisis and home treatment teams (Morriss, 2016). Expectations of increasing demand for AMHPs is further reinforced by rising rates of detentions, increasing year on year (see footnote 2).

Whilst the need for improvements to workforce planning at a national and local level has been urged, this area also poses challenges. The systemic solutions that are needed for responding to such complexity have proved difficult to progress and require multi-levelled actions across a number of local and national government departments. There has also been a lack of high-quality data on the AMHP workforce for coordinated planning. The CQC briefing report (2018) identified concerns about councils' ability to provide a 24-hour

---

[1] http://www.communitycare.co.uk/2016/09/07/warning-severe-amhp-shortages-hundreds-bow/ Community Care online 07/09/2016
http://www.communitycare.co.uk/2016/11/30/amhp-teams-stretched-mental-health-act-detentions-rise/ Community Care online 30/11/2016)
[2] The total number of detentions under The Act continued to rise, increasing by 9 per cent to 63,622 compared to 58,399 detentions in 2014/15 This compares with an increase of 10 per cent between 2013/14 and 2014/15 and is the highest number since 2005/06 (43,361 detentions) a rise of just under a half over the period.

AMHP service, the lack of data on AMHP numbers and lack of council oversight of AMHP provision where this had been delegated to NHS Trusts.

It is also important to consider the length of time it takes to develop an AMHP. With at least one years' experience (often two or three years), one years' training and then up to one year consolidating practice, there is substantial time required to train mental health social workers to be ready to undertake the AMHP role. Any dramatic drop in numbers of AMHPs in a service would have a critical impact on a system without effective succession planning and proportionate terms and conditions or salary.

There is evidence that dedicated local workforce expertise has been a diminishing resource in some local authorities and such activity is often undertaken by AMHP leads or others as part of their role. Workforce interventions put in place to remedy the situation have not always been successful. Organisations may not be using the full range of interventions that might help and little has been done to systematically consider what works or to take coordinated action. Many local authority AMHP leads keep detailed data for local reporting, but there is no national database for collection of data on AMHP numbers or their activity. Each local authority has a statutory responsibility for ensuring that they have sufficient numbers of AMHPs to run a '24/7 service' that can respond to demand. However, the considerable lead-in time for the development of AMHPs (three years minimum from qualification), the limited number of training courses and the significant resource implications for training AMHPs mean that a coordinated strategy across local authorities and STPs is indicated, with a need to ensure that the wider health and social care workforce is involved.

There have also been concerns about the age and lack of diversity of the AMHP workforce across all parts of the community – especially as they have a specific role in reducing discrimination and supporting a human-rights led approach. Certain members of society experience more discrimination in trying to access mental health services. The deaf community has particular issues in relation to communication in MHA assessments. The lesbian, gay, bisexual and transgender (LGBT) community has highlighted the rules around the Nearest Relative as especially challenging and a lack of understanding of social attitudes and mental health (Carr, 2010).

The NHS Benchmarking and ADASS survey (2018) found that 38% of the mental health social work workforce was over 50 years of age, while 77% of the workforce was White British – although there was wide regional variation in this. 76% of the people assessed under the MHA were White British, with 15% from Black British backgrounds and 9% from other or Mixed-race backgrounds. NHS statistics record rates of detention under the categories of White, Mixed-race, Asian or Asian British, Black or Black British and other ethnic groups. The most recent statistics (2017/18) indicate that amongst these broad ethnic groups, rates of detention (under all parts of the MHA combined) for the Black or

Black British groups were highest (288.7 detentions per 100,000), being over four times those of the White group (71.8 detentions per 100,000) (DHSC, 2018; NHS Digital, 2018).

As part of the MHA review, there is a specific group looking at how to reduce the number of detentions for these groups and improve the dignity and outcomes for Black, Asian and Minority Ethnic (BAME) people detained under the MHA. The group has identified that the AMHP should have a key responsibility in protecting and emphasising the human rights of people being assessed or detained and that the workforce needs to be more culturally reflective of the people it works with, to understand the effects of discrimination upon them and be trained to provide the best possible assessment and support. This is summarised in the recent publication 'The impact of racism on mental health' (Bhui *et al.,* 2018):

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

The recommendations of the MHA review (DHSC, 2018) for a new approach are:

- The development and implementation of an Organisational Competence Framework and Patient and Carer (Service User) Experience Tool.

- A mandatory expectation that public services will work within this framework in accordance with existing duties under the Equality Act 2010.

- The provision of culturally-appropriate advocacy to provide a supportive role for individuals of African and African-Caribbean heritage.

- Specific early intervention for people from BAME backgrounds.

- Combatting the effect of unconscious bias within the mental health workforce.

AMHP services are increasingly placed within integrated workforce approaches, especially alongside NHS mental health crisis services and police. The barriers to integration are substantial and, if not considered, can lead to confusion over the AMHP and social work role based in health settings, and feelings that the skills of the AMHP are not being utilised effectively. There has been a tendency for local authorities to transfer staff and services to the NHS under section 75 (s75) arrangements, but without always supporting the NHS Trust to understand how to manage the role of the AMHP or the social work workforce. Equally, the small number of nurses and occupational therapists who have qualified as

AMHPs have not always felt valued. The pressures inherent in integration have been outlined by several authors (Morriss, 2015; Woodbridge-Dodd, 2018).

More recently, there has been sustained action via the AMHP Leads Network. Many local authorities have initiated quality improvement reviews of mental health and there is greater intention at policy levels to address systemic failings in mental health services and to develop joined-up solutions to workforce challenges. HEE (2017) has recently announced the beginning of a framework to detail the longer-term strategy for the mental health workforce, to go beyond the Five Year Forward View for Mental Health in which the role of AMHPs will need to be a key consideration. This is now being implemented by HEE alongside the DHSC and is considering the workforce planning needs of mental health social work and AMHPs.

In the context of the above, the development of a national workforce strategy for AMHPs, informed by up-to-date evidence, has become an important step forward to foster more sophisticated approaches and a longer-term view. This will also enable preparation for the future challenges arising from the review of the MHA and the Approved Mental Capacity Professional role in the Deprivation of Liberty Standards.

AMHP service standards

The AMHP service standards were developed by Robert Lewis and Karen Linde, in consultation with ADASS and the AMHP Leads Network. The purpose of these standards is to ensure a consistent approach to the AMHP role across the country. These standards have been subject to substantial consultation and development by AMHPs and will be considered by Social Work England as part of its review of AMHP education. All local authorities and Trusts should adopt these standards in their employment of AMHPs and use them as a key part of this workforce plan (see Appendix One). This plan is underpinned by these standards.

AMHP regulations

AMHPs are regulated by Regulation 2008 (SI 2008/1206) within the MHA and updated following the MHA 2007 amendments. There are aspects of the AMHPs training and development that must be provided by law, including the AMHP competencies that are contained in the MHA regulations. Here is a summary of the main legal regulations:

3. (1) A Local Social Services Authority may only approve a person to act as an AMHP if it is satisfied that the person has **appropriate competence** in dealing with persons who are suffering from mental disorder.

3. (2) In determining whether it is satisfied a person has appropriate competence, the LSSA must take into account the following factors—

(a) that the person **fulfils at least one of the professional requirements [being one of the four regulated professions allowed to be and AMHP],** and

(b) the **matters set out in Schedule 2.**

3. (3) Before an LSSA may approve a person to act as an AMHP who has not been approved, or been treated as approved, before in England and Wales, the person must have **completed within the last five years a course approved** by the HCPC (soon to be **Social Work England**) or the Care Council for Wales.

4. An LSSA may approve a person to act as an AMHP for a **period of five years**.

5. When any approval is granted under these Regulations, it shall be subject to the following conditions—

in each year that the AMHP is approved, the AMHP shall complete at least **18 hours of training** agreed with the approving LSSA as being relevant to their role.

Schedule Two outlines who can be an AMHP:

(a) a **social worker** registered with the HCPC (Social Work England by 2020);

(b) a **first level nurse**, with the inclusion of an entry indicating their field of practice is mental health or learning disabilities nursing;

(c) an **occupational therapist**;

(d) a **chartered psychologist**.

AMHP competencies

The 2007 MHA Regulations specified the AMHP competencies that must be part of the training and re-approval arrangements by universities and local authorities. Existing AMHPs are tested on these at the point of qualification and after five years of practice. We will have the opportunity to review and update these regulations with the development of the new MHA and its passage through the legislative process. This will need to be led by Social Work England who will take over responsibility for AMHP training.

New competencies have been developed by Anna Beddow at the University of Manchester, in partnership with the DHSC and the AMHP Leads Network, and widely consulted across the AMHP community. These will be considered by Social Work England for inclusion in the new MHA regulations.

The competencies cover a range of areas; both the current and proposed competency headings are included here:

Key Competence 1:

Application of Values to the AMHP role (Current)

Application of Social Perspectives to the AMHP Role (Proposed)

Key Competence 2:

Application of Knowledge: The Legal and Policy Framework (Current)

Application of Knowledge: The Legal and Policy Framework for Mental Health and Mental Capacity (Proposed)

Key Competence 3:

Application of Knowledge: Mental Disorder (Current)

Application of Knowledge: Mental Disorder and Mental Capacity (Proposed)

Key Competence 4:

Application of Skills: Working with Risk (Current)

Application of Skills: Working with Risk and Partnership in carrying out the AMHP Role (Proposed)

Key Competence 5:

Application of Skills: Making and Communicating Informed Decisions (remains the same).

The National Workforce Plan for AMHPs

This part of the document is designed to be separated from the background information and included in the appropriate workforce plans as required.

The development of the AMHP Workforce Plan

This plan provides recommendations for improved national and local workforce planning across health and social care to support the Green Paper for Social Care, the NHS Long Term Plan and the HEE Integrated Mental Health Workforce Plan. It should be viewed alongside the AMHP service standards in Appendix 1.

The purpose of this plan is to provide a national recommendations for the development of the AMHP workforce as a high-quality and high-value workforce that is subject to consistent standards both locally and nationally. AMHPs need to have the tools and the organisational structure in place to do their job. They need to be appropriately supported and resourced. These workforce recommendations, together with the regulations, competencies, education and training guidance and the AMHP service standards, will provide the framework for the support and development of the AMHP workforce.

The authorisation and leadership of the AMHP role comes from the local authority and most AMHPs are employed by the local authority. A successful AMHP service, however, can only be delivered through partnerships working across the health and care sector and the police. AMHPs also need to be accountable to service users and representative groups. The recommendations below should form the basis of each regional STP/ICO workforce plan which should, in turn, report to the HEE and Skills for Care boards.

Improving the working environment for AMHPs – national action

- There should be national AMHP education standards, overseen and implemented by Social Work England, which has the regulatory responsibility for AMHP courses. This should be linked to national re-approval standards and clearly specify the quality expected of AMHP courses.

- There should be a clear national guidance on the level of further training expected to be provided to AMHPs as part of the MHA Regulations. This will be developed by Social Work England in consultation with AMHP leads, local authorities, service users and other stakeholders.

- There should be the development of a CPD and progression pathway for social workers to become AMHPs linked to the Professional Capability Framework.

- There should be a specific pathway supported by the regulatory and professional organisations for occupational therapists, nursing and psychology, to support the development of the AMHP role in the other professional groups, according to their regulatory and professional frameworks.

- There should be comprehensive AMHP service standards followed by all organisations responsible for overseeing the AMHP role and AMHP training. This will include robust national criteria for the warranting of post-qualified AMHPs and re-approval standards.

- AMHPs should be subject to specific training and development around the needs of groups who may be vulnerable to discrimination by the MHA assessment process, including women, people from LGBT community and people with disabilities. People from some BAME communities are more likely to be detained under mental health legislation and so this should include the Organisational Competence Framework and Patient and Carer (Service User) Experience Tool recommended by the MHA review.

- CQC should use its powers under the MHA 1983 to inspect the AMHP service as part of its remit to inspect mental health services in a region.

- There should be a national core job description for the AMHP role. It should be overseen by Skills for Care, ADASS and the LGA working with NHS employers as the employing organisations and be based upon the AMHP standards.

- There should be a nationally agreed data collection process for the AMHP role and mental health detentions. This should be coordinated by Skills for Care and NHS Digital, with the support of NHS Benchmarking, ADASS and NHS Improvement.

- There should be national advice and support, based on the MHA Code of Practice (2015), to ensure that s140 of the MHA 1983 (relating to the provision of beds in urgent situations) is implemented, as recommended by the MHA Review. DHSC 2019).

Improving the working environment for AMHPs – regional action

- Local authorities will act as local leaders for the AMHP service in their area and should be represented at a senior level in local strategic, multi-agency planning for mental health services, such as ICOs, to support the development of whole-system mental health planning – especially in relation to crisis services.

- The AMHP role should be developed within a local integrated mental health workforce plan, delivered through ICOs and health and wellbeing boards.

- Local authorities, working with local partners and within STPs or ICO partnerships must ensure that they understand the work profile of AMHPs in each area and monitor retention and recruitment issues:

  - The number of AMHPs required to provide a service across 24 hours.

  - The workforce and succession planning needed to ensure the ongoing sufficiency of AMHPs.

  - The pressures on the AMHP role, including out of hours.

  - Regional differences in pay or conditions affecting recruitment or retention.

  - Any cross-border issues affecting the AMHP service.

  - The implications of having to assess people out of area or dealing with people placed by other areas.

- Local authorities and partners must also monitor the issues that affect the AMHP service:

  - Monitoring access to and delays to obtaining beds.

  - Monitoring access to s12 doctors.

  - Monitoring access to appropriate conveyance.

  - Monitoring the personal safety of everyone involved in MHA assessments.

  - Monitoring the AMHP service out of working hours.

This local activity data will be collated and reported to the local authority and NHS Trust boards and STPs, Skills for Care and NHS Digital. This should be used to inform best practice and improve services locally.

- Local authorities must keep an up-to-date register of all the AMHPs they approve and authorise with dates and keep these records for ten years.

- Local authorities must have an AMHP lead officer that gives direct management to the AMHP service and oversees all AMHPs in the area, including out of hours. They should be aligned with the local authority and MH Trust management. This officer may

be placed in the NHS Trust if all services are operated under a s75 arrangement but must still update and inform the DASS or Principle Social Worker (PSW) as required.

- Local authorities are also required to have a (PSW) under the Care Act 2014 statutory guidance. It is preferable that they have previous AMHP experience. This role should also oversee the AMHP service and report directly to the DASS, MH Trust and the health and wellbeing board.

- Local authorities and MH Trusts must ensure that all AMHPs (including those in MH Trusts) have support and supervision in line with the regulations. This must be from senior social workers with AMHP experience.

- Local authorities must ensure AMHP professional and legal advice is available, alongside appropriate vicarious liability insurance.

- Local authorities and MH Trusts must ensure that AMHPs have access to training and development programmes in line with the regulations and recommendations from Social Work England.

- Local authorities and MH Trusts should ensure there are local forums where issues affecting AMHP practice can be resolved and there should be high-level reporting and monitoring of these. These should link with NHS board-level governance structures and health and wellbeing boards, and include partners, such as acute NHS providers, children's services, the police and ambulance service.

- Local authorities and NHS Trusts should have a shared workforce plan for AMHPs from non-social work professions and agree how these are supported to qualify.

- The LGA, NHS Employers and HEE should jointly publish guidance on the support required for AMHPs employed by NHS MH Trusts or other organisations.

Improving the recruitment of AMHPs

- Local authorities regionally and Social Work England nationally, should ensure that social work courses within university teaching should provide appropriate information and experience about career pathways within mental health services. This should include opportunities to shadow the AMHP role as students.

- Social Work England should work with higher education institutions (HEIs) within teaching partnerships to develop flexible and accessible master's level AMHP training courses based on the regulations and guidance from the regulator.

- Local authorities and STPs should consider recruitment campaigns and advertisements about the AMHP role for experienced staff from across the eligible professions. HEE is developing career pathways and recruitment for all mental health professionals, so this should be joined up.

- Each local authority and STP should have a clear plan for the number of AMHPs needed from mental health services, learning disability services, older people's services, sensory needs services and children's services.

- The salary and position of AMHPs should be reviewed regionally and across organisations. AMHPs are senior practitioners and should be paid accordingly.

- Social Work England should consider the reform and development of AMHP training courses to ensure improved accessibility whilst quality is maintained.

- Local authorities and HEIs should work to develop a training pathway for prospective AMHPs. This can be used to prepare people for the course and to support more practitioners from non-mental health settings to prepare for training. This can include shadowing assessments or offering a taster day in a community mental health setting.

- Some areas use pre-AMHP training courses to build knowledge and understanding of social perspectives on mental health issues and familiarise students with current academic standards.

Improving the retention of AMHPs

It is recommended that local employers, supported by national guidance, take the following action to improve the retention of AMHPs:

- Local authorities, MH Trusts and STPs should monitor the morale, pressures and workload of their AMHP services and the professionals who work with and support AMHPs. There should be regular audits of these issues and plans to resolve problems through a 'whole-system' regional approach.

- Local authorities should work to reduce disparity in levels of salary, leave or benefits for AMHPs within their region. AMHPs should be paid at the appropriate senior-practitioner level for their responsibility and expertise involved. Disparity between NHS and local authorities should be reduced and those employed in an AMHP role paid at similar levels irrespective of employing organisations.

- Local authorities should consider flexible working patterns for AMHPs and the relationship between community work and AMHP work to reduce levels of stress.

- Consistent out of hours' remuneration rates should be paid by local authorities.

- Local authorities should ensure that enough AMHPs are trained in each area, every year. Course and backfill costs would need to be part of each workforce plan.

- Local authorities should explore ways of encouraging experienced AMHPs to support the next generation of trainees.

- Local authorities should train and support AMHPs across all services, especially children's, disabilities, emergency duty teams and older people.

Training and development of the AMHP role

AMHP services should promote social perspectives of mental health within the broader system and actively seek opportunities to promote child and adult safeguarding, rights-based agenda, early intervention and access to social and health care.

- AMHP professional development should emphasis the value of service user and carer experience of the AMHP role in learning and development. AMHPs should be supported to explore the impact of social trauma on the experiences of detention and how this shapes the responses of both service user and family or carer to the AMHP.

- AMHPs should be supported to take up a system leadership roles and to use their place in the system to effect wider change.

- AMHPs should achieve supervisory accreditation under the Knowledge and Skills Framework for supervisors and have the opportunity to train as practice educators.

- The link between the AMHP practice education role and the social work practice education role should be clarified and developed.

- AMHPs should have routine opportunities to contribute toward the learning of others, identify their own learning needs and be provided opportunities for personal and professional development.

- Routes into AMHP training should be clear for all qualifying professional groups, regardless of employer or profession. All professions who carry out the AMHP role must be supported to maintain the regulated professional registration.

- AMHP services should recognise and support AMHPs outside of AMHP work, where possible, and seek to avoid organisational and professional isolation.

- Social Work England should consider how the current high standards of learning within AMHP courses can be delivered in more flexible ways with AMHP preparation courses

and the opportunity to deliver the course over different timescales and more accessible to staff.

- Specific training and development should support AMHPs to work with client groups outside their normal experience, including emergency duty work.

Promoting the AMHP role in multi-disciplinary and partnership working

- The statutory responsibility for the AMHP role lies with local authorities. The role should also be part of the wider integrated workforce for mental health services, working with NHS employers, HEE and others to develop and support the role.

- Regional workforce plans should support other professions to train as AMHPs through a positive career development and recruitment process, operated via HEE and local STPs and MH Trusts.

- Regional local authorities should develop a local workforce plan to agree the number of AMHPs needed locally and the funding and recruitment arrangements. This should be a shared responsibility across the health and care economy.

- NHS MH Trusts and HEE should work with the LGA, ADASS and the Office of the Chief Social Worker to develop a professional support and HR process for social workers (and AMHPs who are not social workers) employed directly by NHS Trusts that will ensure they meet their regulatory and CPD requirements.

- Local authorities and MH Trusts should agree the enhanced amount to pay AMHPs who are not local authority social workers.

- The Royal Colleges of Nursing and Occupational Therapy and British Psychological Society should support their members to become AMHPs.

References

Allen, R., Carr, S., Linde, K. and Sewell, H., 2016. Social Work for Better Mental Health: A Strategic Statement. DHSC

Allen, R., 2014. The role of the Social Worker in Adult Mental Health Services. College of Social Work.

Association of Adult Social Services (ADASS), 2018. Top Tips for Directors of Adult Social Care.

British Association of Social Workers (BASW), 2016a. All Party Parliamentary Group on Social Work. Report of the inquiry into mental health services in England. London

British Association of Social Workers (BASW), 2016b. Charter for integration.

British Association of Social Workers (BASW), 2019. All Party Parliamentary Group on Mental Health. Social Work and the New Mental Health Act. London

Bhui, K., Nazroo, J., Francis, J., Halvorsrud, K. and Rhodes, J., 2018. The Impact of racism on mental health. [Online]. Synergi Collaborative Centre. [Accessed on 31 May 2019]. Available from: https://synergicollaborativecentre.co.uk/wp-content/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf

Buckland, R., 2014. The decision by approved mental health professionals to use compulsory powers under the Mental Health Act 1983: A Foucauldian discourse analysis. The British Journal of Social Work, 46(1), pp.46-62.

Carr, S., 2010. Seldom heard or frequently ignored? Lesbian, gay and bisexual (LGB) perspectives on mental health services. Ethnicity and Inequalities in Health and Social Care, 3(3), pp.14-23.

Care Quality Commission (CQC), 2018. MHA 1983: Approved Mental Health Professionals.

Department of Health (DoH), 2014. Mental health crisis care concordat: Improving outcomes for people experiencing mental health crisis.

DoH, 2015. Mental Health Act Code of Practice.

Department of Health & Social Care (DHSC), 2018. Mental Health Act Review Final Report. London

Department of Health and Social Care, 2019. Guidance for Clinical Commissioning Group and Local Authority partners on how to implement s140 MHA 1983/2007. London

Dixon, J., Wilkinson-Tough, M., Stone, K., Laing, J. 2018. How AMHPs balance the rights of patients and Nearest Relatives during assessments for compulsory hospital admission under mental health legislation in England. Health & Social Care in Community. Unpublished.

Hargreaves, R., 2000. 'A mere transporter': The legal role of the Approved Social Worker', International Journal of Mental Health and Capacity Law, 4, pp. 135-146.

Health Education England, 2017. Stepping forward to 2020/21: The mental health workforce plan for England.

Laing, J., Dixon, J., Stone, K. and Wilkinson-Tough, M., 2018. The nearest relative in the Mental Health Act 2007: still an illusionary and inconsistent safeguard? Journal of Social Welfare and Family Law, 40(1), pp.37-56.

Morriss, L., 2015. AMHP work: Dirty or prestigious? Dirty work designations and the AMHP. The British Journal of Social Work, 46(3), pp.703-718.

Morriss, L., 2016. Being seconded to a mental health trust: The (in) visibility of mental health social work. British Journal of Social Work, 47(5), pp.1344-1360.

National Collaborative Centre for Mental Health, 2017. ESCASS – effective, safe, compassionate and sustainable staffing.

NHS Benchmarking and ADASS, 2018. AMHPs, MHA & the MH Social Care workforce.

NHS Digital, 2018. Mental Health Act statistics, Annual Figures: 2017-18.

NHS England, 2019. The Long-Term Plan for the NHS. London

Skills for Care, 2018. The Approved Mental Health Professional Workforce.

Skills for Care, Skills for Health, Health Education England, 2016. Mental Health Core Skills Education and Training Framework.

Stevens, M., Martineau, S., Manthorpe, J., Steils, N. and Norrie, C., 2018a. 'Who wants to be an AMHP?' London: Social Care Workforce Research Unit, King's College London.

Stevens, M., Martineau, S. and Manthorpe, J., 2018b. Recruiting & retaining social worker AMHPs: evidence & research agenda. Social Care Workforce Research, King's College London.

Stone, K., 2018. Approved Mental Health Professionals and Detention: An Exploration of Professional Differences and Similarities. Practice, 31(2), pp.83-96.

Stone, K., 2019. Nurse AMHPs: An exploratory study of their experiences. The Journal of Mental Health Training, Education and Practice, 14(2), pp.86-95. [Accessed on 23 July 2019]. Available from: https://doi.org/10.1108/JMHTEP-07-2018-0039

List of contributing individuals or organisations

Authors:

Mark Trewin: Mental Health Social Work Lead, DHSC & NHS England

Karen Linde: Social Work for Better Mental Health. Senior Associate - Centre for Citizenship and Communities (LSE, UCLAN, RSA)

Robert Lewis: AMHP Service Manager, Devon County Council & MH Partnership Trust

Contributing organisations:

AMHP Leads Network

Anna Beddow: Programme Director, MSc Applied MH, University of Manchester

Association of Directors of Adult Social Services (ADASS) National Mental Health Policy Network

British Association of Social Workers (BASW)

Care Quality Commission (CQC)

Chief Social Worker for Adults

Department of Health and Social Care (DHSC)

Health Education England (HEE) Mental Health Workforce Team

National Collaborative Centre for Mental Health

NHS Benchmarking Team

NHS England Adult Mental Health Team

Skills for Care

Social Work England

Appendices

Appendix One: Draft AMHP service standards (Robert Lewis and Karen Linde)

1. Local authority governance and connection to national and regional AMHP networks

1.1 Local AMHP services and leadership structures should be constructed in such a way as to ensure that there is a direct 'line of sight' and regular reporting between 24-hour frontline AMHP services and the responsible Director of Adult Social Services (DASS). Where services are located within mental health partnerships, the chief executives and Trust boards of those Trusts should also be formally sighted on the activity of AMHP services in their area through regular reporting structures.

1.2 The DASS should ensure that a lead AMHP or AMHP manager from their authority is linked into the National AMHP Leads Network forum in order to contribute to, and disseminate information from, that national forum. The DASS is responsible for ensuring that the authority notifies any changes in post-holder to the network to ensure continuity.

1.3 The DASS should ensure that its AMHP workforce is supported to maintain alignment to the AMHP competencies throughout its practice, has access to the appropriate level of continuous training, and has systems in place to manage the register of authorised AMHPs, including the suspension or removal of warrants when required. The DASS should also ensure that AMHP succession and workforce planning remains a central consideration in the management of the service.

1.4 The DASS should work with neighbouring authorities to ensure that cross-border lead AMHP forums are in operation and are supported by its organisations. The DASS should also ensure organisational support for the development and maintenance of wider regional forums, themselves feeding into the National AMHP Leads Steering Group.

2. Governance within 24-hour AMHP services

2.1 AMHP services, regardless of design, should be constructed in such a way as to ensure that AMHPs have clear and timely access to managerial, professional, peer and legal support across the 24-hour time period.

2.2 AMHP services should ensure that referral management and data collection are explicitly supported as part of the routine function of the service; including supporting the completion of National Minimum Data Sets and securing local data sufficient to ensure

informed and robust AMHP services. This data should be shared routinely – in line with legal and information governance requirements – with local partners to support multi-agency working arrangements and to feed into demand planning, strategic commissioning discussions and improvements to local operational practices.

2.3 Each AMHP service should have clear contingency plans in place to ensure capacity is made available at times of high demand, and that lead AMHPs and AMHP managers are empowered and supported to mobilise resources as required.

2.4 There should be clear mechanisms through which AMHPs are able to report issues and delays and for those issues to be directed toward the appropriate body. As stated in the MHA Code of Practice, AMHPs should be supported by their local authority in such circumstances. AMHP service leads should be empowered to work creatively and collaboratively with partner agencies to identify and resolve resource issues.

2.5 The AMHP manager or lead designated to maintain engagement with regional and national forums should ensure essential updates are disseminated throughout local AMHP forums. AMHP services should maintain a record of minutes and attendance at all forums.

3. AMHP service scope

3.1 AMHP services should be viewed as integral to mental health and related services, with representatives encouraged and supported to take an active role in the development of regional and local policy and practice, particularly around areas of prevention, safeguarding, crisis care and multi-agency working. These agencies include, but are not limited to, NHS primary care, general hospital, mental health and ambulance Trusts, police forces and the judiciary.

3.2 AMHP service structures should promote 'localism' to ensure that AMHPs remain connected with, and are integral to, service delivery in local communities. The AMHP service should be able to contribute to the functioning of other specialist teams and services and be viewed as part of the broader safeguarding responsibilities of local authorities and partner agencies.

3.3 AMHP services should be accessible and connected to all mental health service areas and not be limited to adult mental health teams. The interface with other specialist services should be clearly set out and access points promoted with partners.

3.4 The AMHP workforce should reflect the diversity of its communities and targets should be set to reflect this aspiration.

4. AMHPs' personal, professional, physical and psychological safety

4.1 AMHP service arrangements should be configured in such a way as to ensure that AMHPs' safety and well-being is at the forefront of operational considerations and that the expectation to lone-work in non-contained environments is removed.

4.2 Arrangements for supporting AMHPs who have gone past their normal working hours should be clearly set out, including clear contingencies to promote the safety of those staff and how those staff will be compensated for their time.

4.3 AMHP services should support the independence of AMHP decision making, while ensuring that they have access to individual, peer and professional support in order to explore their working practices in a safe manner, including the provision of timely de-brief sessions. AMHP supervision should be viewed as the cornerstone of quality AMHP practice.

4.4 AMHPs should have the opportunity to carry out a full range of AMHP functions in order to maintain practice standards across the workforce, to meet the requirements of re-warranting and to adhere to the AMHP Key Competencies set out in Regulations.

4.5 AMHP services should promote a culture of open and honest communication within their services. AMHPs should have routine opportunities to record and share their experience and contribute to on-going service development.

5. Service and professional development

5.1 AMHP services should be seen as open-learning environments in order to promote social models of mental health within the broader system. AMHP services should actively seek opportunities to promote child and adult safeguarding, rights-based agenda, early intervention and access to social care.

5.2 All AMHPs should be supported to take up a system leadership role and to use their place in the system to effect wider change.

5.3 AMHPs should have routine opportunities to contribute toward the learning of others, identify their own learning needs and be provided opportunities for personal and professional development.

5.4 Routes into AMHP training should be clear for all-qualifying professional groups, regardless of employer or profession. All professions who carry out the AMHP role must be supported to maintain the requirements of their on-going professional registration.

5.5 AMHP services should recognise and support AMHPs who have skills and roles outside of AMHP work, where possible, and seek to avoid organisational and professional isolation.

5.6 AMHP professional development should give emphasis to the value of service user and carer experience of the AMHP role as a spur for learning and development. AMHPs should be supported to explore the impact of social trauma on the experiences of detention and how this shapes the responses of both service user and the AMHP.

6. Improving the experience of people who come into contact with AMHP services

6.1 AMHP services should promote the dignity, human and civil rights of those it comes into contact with and within the organisations AMHPs work. AMHP services should promote personalised and preventative care, equality of access to legal entitlements and aim to reduce stigma. Particular focus should be given to tackling racial and cultural disparity through the development of competence, awareness, staff capability and behavioural change.

6.2 AMHP services should seek to embed the principles of co-production as part of its operations. Services should explore methods aimed at ensuring the patient and carer experience and perspective is captured and harnessed, to support both the development of services and to ensure that this learning is not lost. AMHP services should identify ways in which patients and carers are able to engage and influence the development of AMHP services and AMHP practice.

6.3 AMHP services should promote an understanding of social models of mental health and this should be reflected in AMHPs' recording and reporting systems. AMHP reporting should make clear reference to the principles of the MHA and how the AMHPs have considered these throughout their work with individuals and those connected to them.

6.4 AMHP services should provide access to clear information about the AMHP role, the role of other professionals and advocates in the mental health service. Such information should be co-produced, culturally appropriate and accessible to people with additional needs, such as physical, sensory, learning difficulties and disabilities, and those for whom English is not their first language.