Mental Health Act

Approved Mental Health Professional services

March 2018

Summary

In 2017, CQC completed a collaborative review with national partners and local Approved Mental Health Professionals (AMHPs) to identify themes that support or challenge the effective running of AMHP services. This briefing paper provides an overview of findings from that programme of activity, including:

Factors supporting the effective delivery of AMHP services

- **Leadership –** we heard from individual AMHPs and teams who felt supported with supervision, forums and training.

- **Recognising the value of the AMHP role –** AMHPs told us that they were recognised as the local experts in mental health legislation, navigating the complex legal frameworks and making sure hospital admission should be the last resort to other community alternatives.

- **Innovation and partnership –** AMHPs were keen to share examples of innovative practice to improve focus on prevention and community provision. Examples included areas that had commissioned services that supported the AMHP role being integrated with wider crisis teams and responses.

- **Crisis and prevention –** AMHPs told us of positive examples of how improved access to community-based crisis services could help them to identify alternatives to detention and have a positive effect on outcomes for patients in crisis.

Challenges and barriers to the AMHP role

- **Acute care system capacity** – many AMHPs raised concerns about the pressures on the acute care system and access to specialised and local beds.

- **Workforce –** AMHPs told us of difficulties with recruitment and retention of AMHP workforce.

- **Variation in health and social care integration** – AMHPs told us about the effect of varying levels of integration between health and social care across areas and services.

- **Mental health service commissioning –** AMHPs reported on the effect of adult social care cuts to local authority budgets and increased austerity creating a lack of community provision. There was general concern about the limited access to low level community prevention resources.

Introduction

The role of the Approved Mental Health Professional (AMHP) is critical to the operation of the Mental Health Act (MHA). AMHPs across the country help identify alternatives to compulsory admissions under the MHA, working across local services to support patients and their families during assessment.

This briefing paper provides an overview of findings from a programme of activity in 2017, which looked at the way AMHP services are being delivered across the country. This activity followed a recommendation by the Crisis Care Concordat that the Department of Health and Social Care and CQC should review the effectiveness of the current monitoring of AMHP services. That review found wide variation in the way AMHP services are provided across the country. It recommended further work to support local services and national monitoring should be completed to provide evidence in this area and identify future improvements.

Background

What is an Approved Mental Health Professional?

Approved Mental Health Professionals (AMHPs) work on behalf of local authorities to carry out a variety of functions under the Mental Health Act (MHA). One of their key responsibilities is to make applications for the detention of individuals in hospital, ensuring the MHA and its Code of Practice are followed. It is the AMHP's duty, when two medical recommendations have been made, to decide whether or not to make the application for the detention of the person who has been assessed under the MHA, also known as sectioning. This includes considering the correct legal frameworks (Mental Capacity Act, including Deprivation of Liberty Safeguards), including alternatives to admission, ensuring that the patient is involved, and identifying and involving their nearest relative.

Each local authority must make sure an AMHP service is provided, and they are responsible for the approval and registration of AMHPs. Most AMHPs are social workers, but AMHPs can also come from a range of professions, for example psychology or nursing. There is no national database that tells us how many AMHPs there are in England or that captures how many social workers are also authorised as an AMHP. Typically, individuals will be authorised by the local authority, but will work across a variety of teams in healthcare providers, including community mental health teams, and crisis resolution and home treatment teams. They will also work in emergency duty teams, which are predominantly local authority employed and led.

In our recent briefing on the rise in the use of the MHA, we reported that between 2005/06 and 2015/16, uses of the Act have increased by 40% to 63,622 sections per year. The majority of these sections, plus the 58,920 short term holding powers, will have needed the involvement of an AMHP at some stage in the process. Many

AMHPs also act as Best Interest Assessors locally for the Deprivation of Liberty Safeguards (DoLS). During 2016/17, there were 82,621 applications for DoLS – a 33% increase from 62,237 in the previous year. The increase in the number of uses of the MHA and DoLS illustrates the importance and growing demands on AMHPs across the country over the last decade.

Although CQC are the regulator for health and social care services, and are responsible for monitoring the use of the MHA, AMHP services fall outside our regulatory duties. This is because AMHPs are authorised by local authorities, which are not subject to CQC regulation.

What is an AMHP service?

The Mental Health Act (MHA) places on local authorities the duty to provide AMHP services. Local authorities are responsible for ensuring that enough AMHPs are available to carry out their roles under the MHA, including assessing patients to decide whether an application for detention should be made. They should have arrangements in place to provide a 24-hour service that can respond to patients' needs in a timely way.[ii]

Currently, each local authority is responsible for its own AMHP provision, approval system and standards. There are no set governance processes for how local authorities should run their AMHP services, and in recent years there have been a number of policy and practice developments that have had a direct effect on the way AMHP services are run.

Local authorities have a number of key duties in the MHA regulations in relation to AMHPs who carry out assessments on their behalf, which cannot be delegated to NHS providers.[iii] These include:

- Ensuring that all AMHPs have access to professional supervision and support in their role as AMHPs.

- Provide a minimum of 18 hours of refresher training, relevant to the AMHP role each year – as determined by the local authority.

- Responsibility for the health and safety of AMHPs while they are carrying out assessments on their behalf.

- Responsibility for professional competence in their role as AMHP, and for removing or suspending their warrant as necessary.

- Legal indemnity while carrying out the AMHP role.

- Access to legal advice while carrying out AMHP duties.

[ii] Department of Health, Mental Health Act Code of Practice 2015, page119.
[iii] The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008. Schedule 1

Methodology

In 2016, CQC worked with the Department of Health and Social Care to review the effective monitoring of AMHP services in England, to prepare a report to the Crisis Care Concordat. During the review, we held workshops with AMHPs and were told:

- There are concerns about the numbers of AMHPs and the ability of services to provide a 24-hour service to respond effectively to patients' needs.

- The way AMHP services are being run varies widely across the country.

- Local oversight and reporting of AMHP provision and the data recorded is variable and there is no national data set.

- AMHP services are affected by a number of wider service issues, including access to section 12 approved doctors, ambulances for conveyance of patients, and local area and specialist beds.

To collect further evidence on the current situation we combined meeting with local AMHP services with visits to services, looking at the rising number of Mental Health detentions. This included gathering information from three sources:

- **Data review**: we analysed available data on the use of the MHA nationally and wrote to areas that we visited requesting information from their local systems to help understand how AMHP services were being delivered in their area.

- **Site visits:** during 2017, we visited 23 local authorities, 10 NHS trusts and two independent mental health service providers. We interviewed or held focus groups with more than 60 detained patients, 30 carers and more than 250 staff including AMHP service leads, local authority staff and AMHPs. The interviews and focus groups were open and informal to encourage participants to share their experiences and help inform this national report.

- **Engagement:** throughout the review, we shared and tested emerging findings with our MHA External Advisory Group, Service User Reference Panel and other stakeholders (see appendix).

This report is a summary of the AMHP findings from this activity. It provides evidence to support existing or planned work programmes for other national agencies such as local sustainability and transformation partnerships, local authority commissioners, clinical commissioning groups, and health and wellbeing boards. We also hope local services will find this useful in their own improvement programmes that have an effect on AMHPs and mental health service delivery.

What we found

Factors supporting the effective delivery of AMHP services

Leadership

Most AMHPs described good peer support, supervision and training arrangements with high levels of visible AMHP leadership and local networking. Some services reported that AMHPs had good access to training, updates and legal advice. The experience of AMHPs varied depending on governance arrangements between their approving local authorities and the mental health trusts. This difference was highlighted where some services had been organised into specific AMHP hubs, compared with others operating separately in individual teams. Two services described 'hubs' as areas of good practice, describing a service where AMHPs were able to support each other and share learning. Other areas experienced AMHPs working in isolation and some areas lacked formal AMHP supervision. Some areas were planning 'hub' style services and saw this as a positive move forward.

AMHPs indicated that where AMHP services had a high profile their issues were raised at board level and that AMHPs had high visibility in their trust and local authorities, whereas others felt their voice was 'hidden' and they struggled to get issues recognised at senior management level. These differences appeared to relate to the organisation of the AMHP service, with greater visibility dependent on how services were organised and led. The ability to raise issues specific to AMHPs caused concern among some groups, who felt unable to highlight issues back to their trust. Some of the issues raised were access to section 12 approved doctors and access to beds.

> Some of the AMHPs felt supported by their managers while others felt that there was little support from management who had no understanding of what the AMHPs did, or the pressures on them.
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> There were AMHP forums in all the boroughs that met regularly and shared learning from incidents. Section 75 (the legal agreement between the trust and local authority) performance meetings were held with the trust and any incidents or issues were discussed there and reported to the trust board monthly.
>
> **AMHP focus groups**

Of significance was the ability to report activity and to have access to good data. In some services, the use of data provided a useful tool to inform best practice, and enabled AMHPs to plan services and to report on performance, trends and issues. There was variation in whether and how data was used, which appeared to be linked to trust board and local authority leadership, value and awareness.

It has been nationally recognised that there is a problem with consistent data on local authority mental health services, mental health social work and the provision of AMHPs. Skills for Care do not separate mental health and AMHP specific information

from the data they collect. NHS England collect data on detentions, but the work of AMHPs may not lead to detention. Recently The NHS Benchmarking Network and The Association of Directors of Adult Social Care Services (ADASS) have tried to gather snapshot information and to make sure that there is specific data across local authorities and mental health trusts.

Some areas described monthly meetings between the local authority and the mental health trust to discuss reporting and governance issues, while in other areas section 75 agreements were being dissolved and staff were returning to local authority control. Collation and reporting of data varied substantially across areas; some reported annually to boards, while others shared data across various computer systems or from patient experience surveys. There was frustration at the different data systems in different NHS services and between NHS, independent and local authority services (for example for young people, child and adolescent mental health services (CAMHS) or people with dementia). In some areas, AMHPs felt this was detrimental to sharing information, recording assessments and recording activity.

AMHPs identified difficulties in accessing information about patients because different providers used different record keeping systems. There were six different systems in use across the provider service. This included local authority systems, independent and NHS provider systems.

AMHP focus group

Recognising the value of the AMHP role

Across most services, AMHPs felt that their skills, expertise and knowledge base were recognised in their local area teams. AMHPs were seen as experts locally in mental health law, particularly following the effect of the Cheshire West case and the interface of the Mental Health Act (MHA) and Mental Capacity Act. AMHPs could appropriately challenge the use of detention when they felt it was not appropriate. AHMPs felt that they could challenge the over use of community treatment orders, and were able to support reducing length of stays and improving discharge. Where this worked well it improved patient experience and emphasised the value of the AMHP role in multidisciplinary teams. Two areas described that having AMHPs in their teams supported discussion and reduced inappropriate referrals to mental health services.

AMHPs felt that, while recognised locally, this was not always the case at trust board or local authority level, and understanding about the pressure on AMHPs to get it right and the effect and risk when they get it wrong was not always shared or understood. AMHPs are independent professionals who are responsible for their own decisions and cannot be told what to do. This was highly valued by AMHPs, but not always understood by others.

There was a growing recognition that more could be done by AMHPs to obtain feedback on the experience of people who have been subject to a MHA assessment and to improve the quality of the service provided.

Innovation and partnership

AMHPs reported that reduced access to partner agencies could create delays when organising assessments. This included access to section 12 doctors, police and ambulance services.

A major issue was the difficulty AMHPs experienced in securing a doctor with previous knowledge of the patient. AMHPs felt that the community teams were not committed to being part of assessments under the MHA, and that people who do not know the patient may be more likely to assess a need for hospital admission rather than alternatives.

There was a rota of section 12 doctors available out-of-hours. AMHPs, ward staff and doctors reported that MHA assessments were often delayed until after 6pm because section 12 doctors were not available until then. GPs were not available to carry out MHA assessments, even during the day. It was possible that no-one with personal knowledge of the patient would be present at the MHA assessment.

AMHP focus groups

Where services had good partnership working, AMHPs were keen to share examples of innovative practice, such as where services had commissioned street triage, crisis and home treatment services, crisis cafes or crisis houses, and had good partnership arrangements with local police forces. In addition, AMHPs reported that where services had commissioned independent ambulance services with specialist crews, this reduced the need for police, handcuffs and dependence on acute ambulance services.

AMHPs reported the positive effect of street triage and police hub projects have had on the use of section 136, inappropriate detentions and targeted use of police resources. Some services reported that street triage had reduced the number of section 136 detentions.

These types of innovations are positive developments, but we heard AMHPs and mental health social workers may not always be involved in the development or delivery of the services. As would be expected, involvement is far more likely in the areas where there joint commissioning and good partnerships between the NHS and local authority. In areas where street triage worked well, AMHPs reported important changes in police practice with high levels of people diverted away from hospital without being placed under section 136 and a high proportion of people detained under section 136 who needed an inpatient admission under section.
Some services have developed a short-term admissions/assessment unit, which had a positive effect on reducing longer admissions under the MHA, with positive feedback from both carers and people who had used the service.

The MHA needs at least one of the doctors recommending detention to be section 12 approved (specific approval for doctors to complete MHA assessments) and preferably one doctor who has previous knowledge of the patient. In the case of people unknown to mental health services, it is likely to be their GP who can provide previous knowledge and complete an assessment. However, AMHPs reported that access to GPs for MHA assessments was limited, either acting as the doctor with prior knowledge of the patient or in a section 12 role. We heard that when GPs were involved and knew the patient, this led to a positive outcome and improved the patient's experience. AMHPs also reported that some areas had good collaboration with ward staff to link people back earlier into their communities and reduce length of stays. AMHPs felt that the reduced community provision did not always support people enough and this resulted in readmission and increased detentions.

Crisis and prevention

AMHPs were particularly keen to share positive examples of how improved access to crisis services supported them to deliver a least restrictive alternative to detention and affected outcomes for patients. In particular, AMHPs identified increased community provision and alternatives to admission as useful tools to manage people's crisis at home. AMHPs also identified that only those most acutely unwell needed admission and that this was usually under the MHA, which may indicate a reason for raised detention levels. One service reported that community teams were used more effectively and therefore anyone who was admitted was usually in need of detention under the MHA.

One service reported that community alternatives to admission, such as safe spaces, crisis houses and crisis cafes, and in particular work with the third sector, had a positive effect on admissions under the MHA. Another service identified the provision of support into nursing homes and supported housing provision as a successful initiative. This helped staff to manage challenging situations and support people who use services. Having a devolved budget to the AMHP lead also enabled them to authorise increased funding for one-to-one support at home or short term housing in emergencies to prevent admissions. The development of a crisis house in one service two years ago was also reported to our site visit team as having a positive effect on reducing admissions.

Challenges and barriers to the AMHP role

Acute care system capacity

AMHPs reported that a reduction in beds nationally affected their ability to complete assessments in a timely manner, particularly when specialist beds were needed. Most areas reported a lack of specialist services for young people, children and people with dementia or learning disabilities, which were all mentioned frequently. In some areas acute care beds were also problematic, while others have managed to reduce private sector and out of area placements. Services cited a general lack of mental health beds as a major barrier for patient admissions. AMHPs described crisis

teams using the telephone as means to support patients. Other areas reported substantial improvements when a centralised bed management system was working well, although on occasion AMHPs felt that these systems challenged their decisions and could be a barrier to accessing beds.

> AMHPs told us that requests for assessment under the MHA were increasing month-on-month. In at least 50% of cases, they were unable to make the application due to a bed not being available.
>
> **AMHP focus group**

Accessing beds was described as the biggest issue for AMHPs, with AMHPs stating this "continued to be a problem", and that the "bed manager not always contactable". They reported accessing beds was easier out-of-hours, but that the bed situation in general led to premature discharge and repeat admissions.

In addition, it was reported in one area that in February 2017 there were 32 incidents where assessments under the MHA resulted in recommendations for detention, but that no bed was available. They reported issues with social care placements, and that funding was a key barrier to identifying discharge destinations. Another area described particular difficulties in accessing beds for patients who needed out of area placements, and reported delays due to funding issues.

One area had a specialist community intensive service dedicated to people with a learning disability. AMHPs in this area reported that this reduced detention levels as AMHPs could consider a real alternative to admission.

Some areas have tried to resolve these issues by adopting a whole system approach to bed management, community support and prevention. In these areas, AMHPs were integrated into a process that included alternatives to admission, crisis response and intensive home treatment, police support services, services operated by the voluntary sector, bed management and discharge arrangements.

> In one area, they had introduced a new pathway that had improved the access to beds for older people. This included changes to internal gatekeeping procedures. AMHPs felt this had improved services for that group of patients.
>
> **AMHP focus group**

Workforce

Workforce issues were a repeating theme across most services reviewed. AMHPs talked about an inability to recruit and retain AMHPs. Some felt that despite the changes in the MHA in 2007, which enabled nurses, occupational therapists and psychologists to train as AMHPs, the role was not attractive to new social workers or

other professions. The question asked was how this was being escalated and reviewed, as it was felt to be a national issue not only specific to local areas.

Many areas we spoke to called for a national register and national AMHP job description to support the recruitment and retention of AMHPs. We heard from areas who felt the numbers of new AMHPs was reducing and reported that AMHPs are "handing warrants back in their droves". Other areas described a lack of financial incentive for other professionals who are able to take on the AMHP role. This was mainly due to the disparity between local authority rates of pay and NHS rates of pay. For example, if they are a band seven nurse, they would be paid at a band six level when operating as an AMHP. This means local authority increments were not attractive compared with the responsibilities of the role.

One area reported good access to training and updates, good recruitment practices and succession planning and good access to legal advice. Other areas reported that it was retention rather than recruitment that was an issue. Local authorities recognised that they were losing AMHPs to other areas with more favourable conditions and that a number of AMHPs had retired. However, other areas reported serious concerns about numbers of AMHPs, and the ability of the local authorities to recruit and retain AMHPs to make sure that the service is sustainable.

Variation in health and social care integration

Integration of health and social care services varied across areas and services. Some areas reported good use of section 75 agreements with local authorities and good governance arrangements, while others reported a disaggregation or dissolving of agreements, leaving AMHPs caught between local authorities' priorities and those of mental health trusts. We reviewed several local authorities who had withdrawn from section 75 agreements. In these areas, AMHPs reported that access to AMHP services and response times varied depending on postcode or local authority area. AMHPs reported that they felt this was related to how social care was valued in mental health trusts.

Trust staff felt that the withdrawal of the section 75 agreement meant that the community team is no longer well integrated with the trust. It was apparent that the relationship between the local authority and the trust appeared somewhat strained, with some staff expressing concern about hostility on both sides that impeded their work. We were told that trust doctors no longer come out with the AMHP to do assessments, nurses no longer complete AMHP training and there is a lack of multidisciplinary team discussion that has had a negative impact effect on patients. This view was echoed by the carer we spoke to who told us that, since the section 75 agreement was withdrawn, she has seen a divide in team working and felt that this had affected the care her son has received.

Trust staff and carer focus groups

Mental health services that had AMHPs available in community mental health teams reported clear links to improved timeliness to assessment and improved patient experience. This was particularly evident in areas that had reviewed their AMHP service and were looking at centralising into hub-style services, or planning to increase AMHP provision. Some areas were moving into integrated mental teams and believed this positive move would strengthen relationships between AMHPs, community psychiatric nurses and inpatient nurses.

In areas that had withdrawn from section 75 agreements, AMHPs reported improved social work identity and autonomy. However, they recognised the substantial effect on trusts' mental health teams. Others reported tensions and difficulties between local authority run out-of-hours services and daytime AMHP services.

There was a recurring theme relating to the lack of integration and joint working with other agencies. This included access to doctors (either GPs who know patients, or section 12-approved doctors), alongside conveyance and the use of ambulance services, which were all widely-cited issues across many areas.

Section 75 is not the only option to support joint working and partnership arrangements. We have been told of other localities setting up collaborative working between NHS and social care based on memorandums of understanding, and other local arrangements such as sustainability and transformation partnerships. These arrangements do not need the wholesale transfer of staff and financial arrangements to the NHS, so can be much more positive from the local authority's point of view. It also allows them to implement their statutory priorities and agree joint working based on agreement rather than transfer of power. One outcome of this inspection has been to identify the need for positive examples of integration or partnership, and to make these examples available to areas who are struggling with this.

Mental health commissioning

AMHPs recognised the importance of good, integrated, local commissioning arrangements to their role. There was concern about limited access to low level prevention resources, particularly across social work and social care services, and in line with the Care Act's right to wellbeing and prevention. Some areas reported limited funding across adult social care commissioned services that affected detention levels. One way of resolving this is to make sure that health and social care commissioning is integrated and jointly planned. AMHPs reported that austerity measures and cuts to adult social care budgets were having a substantial effect on prevention services. Some areas felt that austerity, benefit cuts and reduced funding for public health, supported accommodation and housing services were important factors on increased NHS and local authority mental health activity, and increased pressure in the care system.

AMHPs described community mental health teams as being reactive rather than carrying out preventative work. AMHPs felt that additional resources were felt to be needed in order to be able to carry out preventative work.

AMHP focus group

AMHPs described a loss of mental health social work influencing commissioning decisions in local authorities, and emphasised the importance of local authorities taking mental health seriously and seeing it as a core part of their role. Several areas described an increase in support in the community from both health and social care services, but felt that this focused on the most difficult and challenging service users who often had multiple admissions rather than prevention of crisis. This was described as reactive rather than proactive, with more preventative work being needed.

One of the issues that is very important for AMHPs, but rarely a commissioning priority, is the use of section 140 agreements. This is part of the MHA that specifies that clinical commissioning groups should have arrangements in place with the local authority in relation to beds available for urgent admission, which should then be communicated to AMHPs to help them understand available services for people in need of detention. We understand that this is one of the issues being examined by the independent MHA review.

Conclusions and next steps

This report has been developed collaboratively with a range of stakeholders who are leading on various programmes, nationally and locally, to support improvements for AMHPs and AMHP services.

The government have also commissioned a panel to carry out an independent review of the Mental Health Act. They have prioritised carrying out their own examination of the causes of the rising use of detention and of the over-representation of people from Black and minority ethnic groups in the detained population. The role of the AMHP will be particularly important in understanding and improving these areas. We hope that this report will help the AMHP representatives working with the panel to identify solutions, in practice and legislation, which will have a direct effect on the concerns we heard during the review.

Throughout the review we heard of a range of initiatives and proposals to improve the way AMHP services are supported and increase their effectiveness. While it is not possible to include all initiatives in this report, stakeholders felt it was important to offer information and examples for AMHPs and services. This is intended to encourage improvement where projects may be replicated locally by NHS and social care services, or identify future developments that will have an effect on the issues in this report.

Good practice examples from our 2017 site visits

New models of Approved Mental Health Professional (AMHP) service delivery

Greater Manchester Mental Health NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust serves a population of around 1.5 million people and is split across five areas – Bolton, Bury, Manchester, Salford and Trafford. The trust has 832 inpatient beds over 137 locations, with 53,000 service users and 4,750 members of staff.

In Bolton, there are currently 25 AMHPs, all registered qualified social workers, with permanent contracts covering the AMHP rota. Four AMHPs cover emergency duty team work, but do not carry a caseload. There are four AMHPs working in the hub and there has been an investment in creating additional social worker posts to release AMHPs from the community mental health team where they are carrying a caseload. This has been done to enable them to relinquish case load work and focus on the AMHP duties so they can manage this work more effectively.

From 3 April 2017, a newly established AMHP was covering daytime duties seven days per week, 365 days per year. Cover was in place weekdays 9am to 7pm and weekends 9am to 5pm, with emergency duty team cover 6pm to 9am. The daytime rota included AMHPs who worked outside of the hub. This system brought a shared

workload, practice opportunities and maintained competence for all AMHPs.

2gether NHS Foundation Trust
2gether NHS Foundation Trust provides specialist mental health and learning disability services to the people of Gloucestershire and Herefordshire. The area of Gloucestershire is divided into three demographic areas; north Gloucestershire, comprising Tewksbury, north Cotswolds and Cheltenham; south Gloucestershire, comprising Stroud and south Cotswolds; and west Gloucestershire, comprising Gloucester and the Forest of Dean. The demographic area covered by the trust covers 1,887 square miles of both rural and urban landscape, supporting a population of 788,500 people. They employ over 2,300 permanent and bank staff in both clinical and non-clinical support services.

2gether NHS Foundation Trust was the first English mental health trust to make a local declaration in support of the Crisis Care Concordat, and setting up the mental health acute response service (MHARS) has been an opportunity to improve the response for people experiencing crisis. The MHARS service told us they are able to offer an hour's response time. The contact number is widely distributed and anyone in community can access them at any time.

A component of the MHARS team, which is based in the police control room and provides an urgent response to people in crisis, triages calls and forwards this on to the relevant people. Crisis staff rotate into the rota. We were told that a lot of responses that need a response in one hour come via the police.

Although it is early days for the service, people that we spoke to are committed to improving crisis services across Gloucestershire.

The trust have identified that the current model of AMHP provision is not sustainable and are therefore looking at reconfiguring services to a hub and spoke model, and have secured an extra £500,000 to support this change.

The trust has several workstreams to look at change across all areas, and to help it move forward and become more effective.

Training, supervision and accreditation

Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham and Solihull Mental Health Foundation Trust provides a comprehensive mental healthcare service for residents of Birmingham and Solihull, and to communities in the West Midlands and beyond. The trust operates out of more than 50 sites serving a population of 1.2 million, with an annual budget of £237 million and a dedicated workforce of over 4,000 staff.

At Birmingham and Solihull NHS Foundation Trust there was a structured reaccreditation process for AMHPs. This was portfolio-based, including a report from

their line manager, an observation of their practice, and a critical review of their AMHP development. This was submitted to a re-approval panel for consideration. AMHPs were allowed a day to prepare their portfolio for submission to the panel.

The AMHP service was proud of the robust training package for new AMHPs. Between four and six candidates started training every year. The University of Birmingham provided this training.

AMHPs must attend at least three continuous professional development days every year. There was a generous training budget to support AMHPs development. AMHPs receive legal updates at least three times a year to advise them of important changes to legislation and case law. AMHPs have access to an on-call legal advisor if necessary.

AMHPs receive regular supervision, and can attend the AMHP forum for peer support and professional development.

Reviewing workforce capacity

Cornwall Partnership NHS Foundation Trust

Cornwall Partnership NHS Foundation Trust provides a range of mental health and physical health services to children and adults across Cornwall and the Isles of Scilly. Cornwall's population estimate in 2015 was 549,400, with some increase in the proportion of older adults. The trust has eight inpatient mental health wards to which patients may be detained, including a psychiatric intensive care unit and a low secure ward for men.

The trust works in partnership with Cornwall Council, which employs the AMHP, with the exception of a training manager who is employed by the trust. There are 38 whole time equivalent (WTE) AMHPs in the county. This includes 8.5 WTE AMHPs (excluding the principal social worker and the team manager) in the council. The AMPHs are also Best Interest Assessors. The remaining AMHPs are seconded to the trust under a section 75 partnership agreement (National Health Service Act 2006). The trust's head of social work reports directly to the mental health services chief operating officer. The AMHPs working with the trust are located in two home treatment teams and their integrated community mental health teams.

The trust and council have worked together to look at the capacity of the AMHP service, identifying any pressures. Examples of current strategies and approaches to staffing include:

- Carrying out an audit, covering three months, which established that 51% of all detentions under the Mental Health Act (MHA) are being completed out-of-hours, which is between 5pm and 9am on weekdays or anytime at weekends. This means there is a larger demand on the AMHP service when there are fewer AMHPs working (three people from 5pm to 8pm, and one person from 8pm to

9am). The trust and the council are now considering the reasons for this and reviewing day-time working hours with a view to reducing the AMHPs' out- of-hours workload.

- Offering a support package for the current AMHP workforce, with AMHPs telling us they had good access to training and updates. This meant they felt well supported with protected time for learning, good recruitment practices and succession planning. They also reported good access to legal advice when needed.

- All Cornwall AMHPs had a social work professional background, but the organisations are keen to recruit from other professional groups. There were 10 candidates waiting to start the AMHP professional training at the time of our visit.

Good practice examples from NHS England's project team

AMHP development good practice example: Devon

Devon redeveloped its AMHP service into a number of small specialist AMHP hubs across its largely rural locality in 2014. This development has led to increased retention and job satisfaction, better joint working with crisis teams, advice to police and engagement with services to improve prevention. Lone working and staff stress were major issues, but have now improved. Social supervision and other specialist roles can be carried out. The AMHP role is now an important part of the regional mental health services.

Read more about Devon's AMHP service

AMHP development good practice example: Bradford

As part of the Crisis Care Concordat multi-agency process, Bradford redesigned their mental health acute and crisis services so that all services were working together as a whole. This included a new first response crisis service, enhanced home treatment teams, staff based with the police, two crisis safe spaces based in the VCS and improved discharged planning with access to supported and social housing.

AMHPs and social workers were fully involved in this and were part of the community, crisis, home treatment and discharge teams, and based with the police and safe spaces. The duty AMHP hub was integrated alongside the crisis and home treatment teams so that decisions about alternatives to admission could be made early.

This led to a major reduction in bed availability issues, reduced use of police cells and section 136 and no use of private sector or out of area beds in acute care. AMHP working arrangements were substantially improved.

Read more about Bradford's system redesign

National programmes of work

The programmes of work that follow have been highlighted by the stakeholders we worked with as having a direct, or related, effect on improving the provision of AMHP services. The programmes are at different stages of their development and the latest information should be accessed via the webpages for each of the programmes or projects listed.

Independent review of the Mental Health Act

The independent review of the Mental Health Act will:

- look at how the legislation is currently used

- look at its effect on people who use services, their families and staff

- make recommendations for improving the legislation and related practices.

The review will be chaired by Professor Sir Simon Wessely, a former President of the Royal College of Psychiatrists. The review will emphasise how to reduce detentions and the effect of detention under the MHA on people from a Black and minority ethnic background. The important role of the AMHP will be considered by the review and AMHPs will have a key role in the review consultation. Professor Wessely and his team will produce an interim report in early 2018 and develop a final report containing detailed recommendations, by autumn 2018.

Read more about the independent review of the Mental Health Act

Social work for Better Mental health

Social Work for Better Mental Health is a national development project supported by the Department of Health and Social Care that has been running since 2016. The project gives a specific locality the opportunity to review how mental health social work operates in their area. This allows local staff, managers, people who use services, carers and partner agencies to conduct an audit on the effectiveness of mental health social work, the role of the AMHP and the model of integration with health and other agencies. Forty areas are currently engaged and there will be a community of practice established in 2018.

The project reviews organisational models for social work in mental health, including AMHP services, nationally. This will include the nature and levels of social work (including AMHPs) support, leadership and professional development, recruitment and retention. Updates are expected publically in early 2018.

The Social Work for Better Mental Health resources are available here. The programme leads can be contacted by emailing: swfbmh@outlook.com

Social care data collection

One of the issues for the development of the AMHP role has been the lack of information about AMHP activity, the number of AMHPs and their role in mental health services and adult social care. There are currently a number of projects being

developed to resolve this. NHS Benchmarking is working with the Association of Directors of Adult Social Services (ADASS) to support local authorities and mental health trusts to provide information for a snapshot of AMHP data that will then be published and updated by NHS Digital. It is recommended that all local authorities and NHS trusts should make sure that specific data relating to AMHPs and MHA activity is recorded.

Read more about the social care data collection

All-party parliamentary group on mental health social work

The group met and heard evidence in 2016 on mental health social work and this included the role of the AMHP, led by the MP Emma Lewell Buck. As the report states: "Social Workers fulfil a vital role in protecting people's rights when they are in crisis or a situation has deteriorated, particularly through their work as AMHPs."

Read more here

The Think Ahead programme

The training and development of AMHPs is a vital part of this report. This should include ensuring that high-quality university-based AMHP courses remain available. In addition, mental social work training courses like The Think Ahead programme are working to prepare trainees for future roles as AMHPs. This programme seeks to strengthen mental health social work by attracting graduates and career-changers, delivering innovative training, and working with mental health services to maximise the contribution of social work.

The programme provides a new postgraduate route into mental health social work, and is rapidly producing qualified social workers who are well-placed to train as AMHPs. The social work training is based full-time in statutory mental health settings, including shadowing AMHPs.

More information about Think Ahead is available at www.thinkahead.org

Sustainability and transformation partnerships

NHS England will make sure that sustainability and transformation partnerships are made aware of this report and the issues it covers given their system-wide overview of health and social care services across local health economies. There are clear opportunities around integrated workforce planning, and joining up strategic thinking as well as operational working. This is in a wider national context of the need for Mental Health Act processes to function more effectively, in a timely manner and with the needs of people who use services front and centre.

Read more about the Sustainability and transformation partnerships

The Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. Every locality in England has a Crisis Care Concordat plan that develops a whole system approach to improving integrated services. The Concordat focuses on four main areas:

1. Access to support before crisis
2. Urgent and emergency access to crisis
3. Quality of treatment and care when in
4. Recovery and staying

Read more about the Crisis Care Concordat

NHS England adult mental health out of area placement programme

NHS England and NHS Improvement have established a major national programme to support local areas to eliminate non-specialist out of area placements by 2021. NHS England is also developing plans to address out of area placements for specialist inpatient care, including through new care models schemes, bringing together pathways of care across different NHS commissioning boundaries. Local authorities and AMHP services should work with NHS commissioners and providers to contribute to drawing up and implementing these plans given their unique understanding of demand for MHA assessments and admissions under section.

Read more about the out of area placement programme

King's College London AMHP study: Who wants to be an Approved Mental Health Professional?

This study has been commissioned by the Department of Health and Social Care to explore the reasons why other professionals have not taken up the AMHP role in the numbers expected and what can be done to develop the AMHP role. It is due to report in 2018.

Read more about the project.

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- 2gether NHS Foundation Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Cornwall Partnership NHS Foundation Trust
- Cygnet Healthcare
- East London NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northumberland Tyne and Wear NHS Foundation Trust
- St Andrews Healthcare
- Sheffield Health and Social Care NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust

Areas of local authority and clinical commissioning groups

- Birmingham
- Blackburn with Darwen
- Blackpool
- Bolton
- Cornwall
- Gloucestershire
- Hackney
- Kingston
- Lancashire
- Leeds
- Luton and Bedfordshire
- Manchester
- Merton
- Newham
- Northamptonshire
- Richmond
- Salford
- Sheffield
- Sunderland
- Sutton
- Trafford
- Tower Hamlets
- Wandsworth

Mental Health Act Advisory Group and Service User Reference Panel

We are also very grateful to the members of our Mental Health Act Advisory Group and Service User Reference Panel (currently and previously detained patients), who have provided advice and guidance as we developed the scope and methodology, and considered the findings and how to use them to encourage improvements.

Members of our Advisory group include: Department of Health, National Survivor User Network, NHS England, Royal College of Psychiatrists, NHS Providers (Foundation Trust Network), Mental Health Alliance, Human Rights Implementation Centre, Black Mental Health UK, Association of Directors of Social Services, NHS Digital, NHS Confederation, Approved Mental Health Professional Leads Network.