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Approved Mental Health Professionals, Best Interests Assessors and People with Lived Experience: An Exploration of Professional Identities and Practice

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Approved Mental Health Professionals, Best Interests Assessors and People with Lived Experience

An Exploration of Professional Identities and Practice

A report prepared for Social Work England
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Jill Hemmington, Matthew Graham, Alan Marshall,
Andy Brammer, Kev Stone and Sarah Vicary

University of
Central Lancashire
UCLan

Sheffield
Hallam
University

Research team details:

Jill Hemmington

Jill is a Senior Lecturer and course leader for the University of Central Lancashire's Approved Mental Health Professional (AMHP) qualifying and post-qualifying refresher training and education, both of which are delivered nationally. Prior to this Jill worked in and managed a Community Mental Health team, acted as an Approved Social Worker (ASW) and she is now a practising AMHP. She is completing a PhD in AMHP (shared) decision making and power in Mental Health Act assessments. Jill is published in the field of statutory mental health work.

Matthew Graham

Matt is a Senior Lecturer in social work at the University of Central Lancashire. He is course leader for the Best Interests Assessor (BIA) qualifying programme and is a module leader and tutor on the AMHP qualifying programme. He specialises in teaching, training, and is published in the area of the Mental Capacity Act 2005. Matt is a registered social worker and previously practiced as an Approved Social Worker.

Alan Marshall

Alan is a Senior Lecturer in social work at Sheffield Hallam University. He runs the BIA and AMHP qualifying programmes as well as teaching law, mental health and safeguarding across social work and nursing courses. Alan has previously worked as an AMHP for over 10 years.

Andy Brammer

Dr Andy Brammer is an Associate Lecturer at Sheffield Hallam University. He teaches on the AMHP and BIA courses and other post graduate adult social work modules. He is the AMHP lead for Wakefield Council and a qualified AMHP and BIA. His substantive role is in the MHA/MCA professional support team. He has completed a PhD in the decision making of AMHPs undertaking community assessments.

Kev Stone

Dr Kev Stone is an Associate Professor and Lead Social Worker at the University of Plymouth. He is a practicing AMHP, qualified BIA and was a university AMHP programme leader. His research interests include the changing landscape of the mental health workforce and the socio-legal effectiveness of mental health legislation. Kev delivers CPD education and has published widely in these areas, notably the AMHP and BIA Practice Handbooks.

Sarah Vicary

Dr Sarah Vicary is Associate Head of School at The Open University. Prior to her academic role she worked in mental health services, including as an ASW and manager of a mental health crisis service. Sarah was for 9 years a Mental Health Act Commissioner. Her PhD explored the role and experiences of AMHPs. She is widely published in social work and mental health including the AMHP Practice Handbook. She was academic adviser on the award-winning BBC documentary Psychosis and Me.

Data Analysts:

Dina Poursanidou

Dr Konstantina (Dina) Poursanidou is a Service User Researcher in mental health. Her doctoral and post-doctoral research has spanned a range of fields including mental health, education, child health, youth justice and social policy/social welfare.

Darrell Brooks

Dr Darrell Brooks is a Senior Lecturer (Physiology) with the Bachelor of Medicine and Bachelor of Surgery (MBBS) and Physician Associates programmes with the School of Medicine at UCLan. He is interested in clinical and health physiology and the use of 'Extended Reality' technologies for data visualisation in medical education and training.

Participant acknowledgements:

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Background to this study

Social Work England was established under The Children and Social Work Act 2017. It is the specialist regulator for social workers in England. Social Work England officially took over from the Health and Care Professions Council (HCPC) in December 2019. It is a non-departmental public body, operating at arm's length from the government. Social Work England has become the professional regulator for Approved Mental Health Professionals (AMHPs) and Best Interests Assessors (BIAs). In 2020-21, Social Work England has been developing the regulatory framework to support AMHPs and the new specialism of Approved Mental Capacity

Professional (AMCP), which will succeed BIAs from April 2022. This includes the development of education & training approval standards as well as specialist standards for AMHP and AMCP practice.

Social Work England commissioned this piece of work as part of a commitment to learning about the professionals in these specialisms and people's experiences of them. The objective of this research was to undertake a study into the experiences of AMHPs and BIAs and those who have experience of their interventions. Existing research is generally inconclusive and little is known about this area.

Overview of project

Aims of this research project were to further understand:

- AMHPs' and BIAs' views and feelings on their professional identity (in terms of their regulated profession) and the effect it has on their practice

- Whether AMHPs' and BIAs' views and approaches to their practice differ across the regulated professions, as well as any impact this might have on people's experiences of the support provided

- The experiences of people who have received services from AMHPs and BIAs, or those who work with them, and whether their experiences and perceptions differ across the professions

- Whether BIAs intend to convert their status to AMCP[1] and ways in which this has been influenced

Two workstreams were established:

- Workstream one: Experiences of AMHPs, their colleagues and people with lived experience of AMHPs

- Workstream two: Experiences of BIAs, their colleagues and people with lived experience of BIAs

The research was carried out with these overarching objectives in mind and key insights are set out below. The report sets out brief literature reviews which underpin the findings from all stages of the research project.

The project was planned and designed co-productively with people with lived experience of Mental Health Act assessments. The planning phase indicated people may not know the professional background of the AMHP or BIA undertaking the assessment. We also know that AMHPs' and BIAs' professional identity is highly nuanced and is influenced by many variables including:

- Professional (in terms of their regulated professional background as social workers, registered nurses, occupational therapists and psychologists)

- Organisational (for example, where team setting or type may have an influence), and

- Personal (including where core values influence the work)

The research team therefore developed a project that was designed to explore these various nuances and variables and to provide all participants with an opportunity to reflect on and discuss the nature of the work quite broadly.

[1] We do not currently know exactly what the conversion process will be as it is still being developed at the time of writing

We analysed this data for the key themes arising from AMHPs' and BIAs' perceptions of their own and their colleagues' identities and practice. We were keen to understand – from all perspectives – whether it matters that an AMHP or a BIA is from a social work, nursing, occupational therapy or psychology background. If so, we aimed to explore how it influences the way that the work is carried out and the way that it is experienced by people with lived experience of the work. Given the complexity involved we aimed to explore these from a subjective, experiential point of view. We wanted to understand where experiences were shared and what the data revealed around differences.

Approach

A multi-method approach was used so that we could hear from as many people as possible whilst also capturing some depth and trying to understand people's experiences and perceptions about AMHP and BIA work in detail.

We opened the project with a quantitative research approach. We carried out a survey with AMHPs and a separate survey with BIAs so that we could develop a general understanding of the work environment and to seek to understand key themes as identified by AMHPs and BIAs themselves. We used these key themes to inform our qualitative approach with AMHPs and BIAs.

Our qualitative research approach then enabled us to add depth and detail to the survey data. We held focus groups with

AMHPs and BIAs to explore professional identities, challenges, motivations and what could be learned from their experiences and views more broadly.

At the same time, we interviewed people who have lived experience of Mental Health Act assessments, assessments of capacity and those who were relatives or carers of people who have experienced assessments. We approached existing networks and organisations for people with lived experience and we interviewed all of those who volunteered to take part.

Overview of Methods

Quantitative Approach

The survey was distributed through the national networks of professional leads for AMHPs and BIAs. The networks are self-organised groups of professional leads operating regionally and nationally with a reach of 343 local authority areas. The survey was sent to these professional leads and then cascaded to individual BIAs and AMHPs. This enabled an extensive national approach to professionals from different local authorities, healthcare Trusts and independent practitioners undertaking work within these organisations. Surveys were carried out between 22nd February 2021 and 8th March 2021.

At the end of each survey, respondents were invited to take part in a focus group by clicking an 'opt in' button and expressing an interest. Prospective focus group participants were then invited to attend on the pre-advertised dates.

AMHP Survey

All 258 respondents were qualified and practising AMHPs. There were 247 social workers, 10 nurses and 1 occupational therapist. There was a mix of types of service or team structures that the participants worked within.

BIA Survey

All 248 respondents were practising BIAs. There were 221 social workers, 22 nurses and 5 occupational therapists. There was a mix of types of service or team structures that the participants worked within.

As there was a survey for both AMHP and BIA it is possible that a participant completed both surveys if they were practicing in both roles.

Two BIAs and one AMHP explicitly stated that they practiced in Wales.

Qualitative Approach

Qualitative research was undertaken with AMHPs, BIAs and people with lived experience of their interventions. All interviews were undertaken using online (Microsoft Teams) meetings or by telephone.

Focus groups

All AMHPs and BIAs who volunteered and were available on the pre-arranged dates took part in the focus groups. There were:

- Four 90 to 120 minute focus groups with an overall total of 21 qualified, practising AMHPs (19 social workers and 2 nurses)

- Four 90 to 120 minute focus groups with an overall total of 28 qualified, practising BIAs (23 social workers and 5 nurses)

Interviews

- Fourteen individual 30 to 60 minute semi-structured interviews with people with experience of Mental Health Act assessments with AMHPs or ASWs (the forerunner to the AMHP role)

- Two individual 30 to 60 minute semi-structured interviews with people who have acted as Nearest Relative (a legal role under the Mental Health Act 1983 as amended 2007)

- One individual 30 to 60 minute semi-structured interview with one person with lived experience of being assessed on their capacity to make a decision

- Two individual 30 to 60 minute semi-structured interviews with relatives of someone who has had an assessment of capacity

Workstream 1:
Approved Mental Health Professionals (AMHP)

Approved Mental Health Professional: overview of the AMHP role

Under the Mental Health Act 1959 the role of the Mental Welfare Officer (MWO) included the coordination of doctors and, where necessary, ambulance and police as part of an individual's admission to hospital. The review of the 1959 Act acknowledged the relative independence of the MWO from healthcare settings and accepted the need for a counterbalance to medical opinion (Hargreaves, 2000). It acknowledged that the role should be to continue to make an 'independent evaluation […] focusing on the person's family and community environment' and that it should include the ability to 'refuse to authorise an admission if there are less restrictive community settings in which treatment can be provided' (Gostin, 1975 p.37). This view was endorsed by the British Association of Social Workers (BASW) who noted that the mental health social worker has a role which complements medical opinions but that must be from a basis of professional autonomy and independence as a valuable safeguard for the person. The government accepted the case for a parallel 'social assessment' and the MWO role became that of the Approved Social Worker (ASW) within the Mental Health

Act (1983) with local authorities retaining oversight of the role. The AMHP role was created with the 2007 amendments to the 1983 Act, replacing the ASW, and is no longer limited to social workers. Instead, they can be registered social workers, mental health or learning disability nurses, occupational therapists, or chartered psychologists. AMHPs continue to undertake the statutory role on behalf of local authority social services departments who remain legally responsible for AMHP services.

AMHPs must demonstrate competence by completing a course that has been approved by the appropriate regulatory body (Social Work England or Social Care Wales) and must satisfy the competencies and values set out in Schedule 2 of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 in order to be approved (or re-approved) to act as an AMHP by a local authority in England[2]. They must maintain alignment to these competencies throughout their practice in order to be re-approved by the local authority every five years (Department of Health and Social Care, 2019).

[2] In Wales the Mental Health (Approval of Persons to be Approved Mental Health Professionals) (Wales) Regulations 2008 apply

Guiding Principles

All those undertaking functions under the Mental Health Act 1983 (as amended) have specific responsibilities to follow the overarching guiding principles of the Act, as laid out in its Code of Practice (Department of Health, 2015). In practice, it is the AMHP who most closely applies the principles which 'should always be considered when making decisions in relation to care, support or treatment provided under the Act' (Department of Health, 2015 para 1.1). The overarching principles are:

- Least restrictive option and maximising independence

- Empowerment and involvement

- Respect and dignity

- Purpose and effectiveness

- Efficiency and equity

Independence

As an independent statutory role, 'nothing […] shall be construed as authorising or requiring an application to be made by an AMHP' (s.13(5) MHA). The Code of Practice to the Mental Health Act in England (Department of Health, 2015) confirms that:

> Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the

Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principles (para.14.52)

Independent from health services by design, the AMHP role also brings with it an imperative to protect people's rights within a social model of mental health provision (Department of Health and Social Care, 2019). AMHPs' duties and powers are therefore intended to be complementary rather than subordinate (Walton, 2000) and to support the safeguarding of the civil rights of people who use services.

In addition to independence from medical practitioners there is also independence from employers or organisational management structures. Although the AMHP is acting on behalf of the local authority, they act independently when performing functions under the Act. The Code of Practice in England asserts that any undue pressure that might undermine independence should be challenged through relevant local channels (Department of Health, 2015 para. 39.18). The AMHP should exercise their own judgement, based upon social and medical evidence, and not act at the behest of their employer, medical practitioners or any other persons who might be involved with the patient's care (see Jones, 2020 pp. 130-131 for more detail around the independence of the AMHP role).

The social perspective

The ASW role (which preceded the AMHP role) was created under the Mental Health Act 1983 to counterbalance the existing clinical psychiatric model with a more holistic 'social perspective' which would enable less restrictive, community-based alternatives to hospital (Gostin, 1975). Decision-making goes beyond legal and medical perspectives (or tensions) with a third element, the social perspective, acting as a balance (Hatfield et al., 1997). The Mental Health Act Commission (1995) advised that the ASW's role should be wider than merely responding to crisis requests for admission and the AMHP role is still intended to be 'a social counterweight to the medical viewpoint in the detention' (Bartlett & Sandland, 2014 p.259). Recent research concluded that the social perspective was embedded in the practice of the AMHPs studied (Karban et al., 2020).

Coordination

It is the AMHP who has overall responsibility for coordinating the process of assessment (Department of Health, 2015 para. 14.40). Their role is to 'arrange and coordinate the assessment taking into account all factors to determine if detention in hospital is the best option for the patient or if there is a less restrictive alternative' (Jones, 2020 p.127). This entails navigating complex inter-agency arrangements (Department of Health and Social Care, 2019).

With the exception of emergency detentions, or statutory interventions within the criminal justice system, decisions involve three professionals:

- an AMHP;
- a doctor approved under section 12(2) of the Mental Health Act 1983 (amended 2007) with specialist knowledge in treating mental disorder (known as a 'section 12 approved doctor'); and
- a doctor who has previous acquaintance with the person where possible or, if a doctor with previous acquaintance cannot be found, a second section 12 approved doctor.

Alternatives to admission

In keeping with the principle of 'least restrictive option and maximising independence', before it is decided that admission to hospital is necessary, decision-makers should always consider whether there are less restrictive alternatives to detention. This would include informal admission or support in the community, for example from a crisis team or crisis house (Department of Health 2015, paras 14.7; 14.11).

Nearest Relative

Communication with the Nearest Relative is a significant part of AMHP work. When undertaking Mental Health Act assessments AMHPs are required to identify a person's Nearest Relative from a list defined within section 26 of the Mental Health Act 1983 (amended 2007). The AMHP is expected by law to have regard 'to any wishes expressed by relatives' (section13) and to inform the Nearest Relative that a detention for assessment has been or is about to be made. In some circumstances, including detentions for the purposes of treatment, the AMHP is required to consult with the Nearest Relative to seek their views and establish whether they object, in which case the detention can not go ahead. The legislation intended that every person who is subject to a Mental Health Act assessment should have a Nearest Relative and, if a suitable one cannot be identified, a Nearest Relative should be appointed by the Court.

The Nearest Relative has specific rights and powers, such as the right to be informed or consulted when their relative is to be detained, and the power to make an application for their relative's discharge from hospital. Whether or not these rights and powers actually protect people from unwarranted compulsory hospital admission is an area of tension (Laing & Dixon et al., 2018), although AMHPs generally see it as such (Dixon & Wilkinson-Tough et al., 2019).

Approved Mental Health Professional:
Review of the literature

Alternatives to hospital have consistently been lacking and there has been a significant reduction in mental health resources within both hospitals and the community which has profoundly affected the AMHP role (Barnes et al., 1990; Hudson and Webber, 2012; Crisp et al., 2016; Care Quality Commission, 2018; Stevens et al., 2018). This is particularly acute in relation to access to hospital beds, the availability of alternatives to admissions and the functioning of crisis and home treatment teams (Morriss, 2015; Hall, 2017). Assessments are frequently delayed with people's needs not being met (Department of Health and Social Care, 2019).

Inadequate provision of resources and alternatives to hospital, combined with an increase in social stressors and mental ill-health risk factors, lead to a mental health system which is overly reliant on hospitalisation (Care Quality Commission, 2019). Without a range of suitable resources people risk being detained by default rather than by necessity (Care Quality Commission, 2018) as detention is an 'overused last resort' (Bonnet and Moran, 2020). AMHPs are under 'extreme pressure' and 'feel forced' to compulsorily detain in the absence of a less restrictive option (Care Quality Commission, 2015). AMHPs have argued that greater investment in preventative mental health services and 'low intensity' support and

crisis services (including non-medical alternatives to hospital) would help to mitigate the impact of social risk factors on mental health (Bonnet and Moran, 2020).

There is a widespread view that the AMHP role is low profile and has not been given the full support, recognition, review and structure that it requires in order to be completely effective (Evans et al, 2005; 2006; BASW, 2016; ADASS, 2018; Care Quality Commission, 2018; Stevens et al., 2018). There is a perceived lack of understanding or support for the role by NHS Trusts and a lack of support for 'health-based' AMHPs from some local authorities as well as cultural issues between health and social care (Stevens et al., 2018). Many ASWs also believed that their role was misunderstood by people who use services and their families (Gregor, 2010). ASWs and AMHPs have reported feeling undervalued, receiving little recognition and feeling poorly paid, both in comparison with other professionals involved in Mental Health Act assessments and given the level of responsibility the role confers (Huxley et al., 2005; Department of Health and Social Care, 2019).

Inconsistent levels of supervision and an over-dependence on peer support has been a longstanding theme (Gregor, 2010; Furminger and Webber, 2009; Hudson and Webber, 2012).

AMHP work is experienced as emotionally difficult and mentally draining (Evans et al., 2005; Morriss, 2015). Stress and low morale (often attached to recruitment and retention problems) has continually been cited as a core problem with the work (Huxley et al., 2005; Evans et al., 2005; Care Quality Commission, 2016; BASW, 2016). Perceptions of fear and risk related to coordination responsibilities and the use of coercion have been identified (Coffey et al. 2004; Huxley et al., 2005, Buckland 2016). The same has been found for equivalent roles in Northern Ireland (Manktelow et al., 2002) and Scotland (Allen and McCusker, 2020).

AMHPs expend large amounts of emotional labour coordinating complex and risky situations, supporting people who use services and their families, trying to mobilise support and resources and often waiting for beds or ambulance transport (Allen et al., 2016). AMHPs are also required to be 'task jugglers' with a range of roles (Quirk et al., 1999; Leah, 2020). Quirk et al (2003) indicated a 'hate figure' or 'social policeman-executioner' identity attached to the role, illustrating the ways in which stress and pressure arises from the perception that AMHPs are 'agents of social control' and are often challenged when trying to balance the needs of the state, the wider public and the person themselves (Campbell 2010).

Multidisciplinary and multiagency working have consistently been recorded as problematic, with difficulties in coordinating the ambulance, doctor(s) and police (Prior, 1992; Bowers et al., 2003; Fakhoury and Wright, 2004;

Furminger and Webber, 2009; Morriss, 2015). Interprofessional tensions are also likely to be exacerbated in organisational contexts where resources are scarce, for example around transporting detained individuals to hospital, particularly if both police and ambulance officers are required (Quirk et al., 2003; Department of Health and Social Care, 2019). AMHPs show frustration at being 'abandoned' where they are literally left on their own at the scene, experiencing this as being left to undertake tasks with low prestige (Matthews, 2003, Vicary et al., 2019). AMHPs work within complex organisational systems and it is widely recognised that they operate most effectively within a whole-systems approach where the NHS, local authorities, police and other agencies work together (Care Quality Commission, 2018). Difficulties accessing section 12 approved doctors, liaising with the police and ambulance services and uncertainty about working hours are further factors (Stevens et al., 2018).

Research undertaken during the planned revisions to the 1983 Act (Evans et al (2005; 2006; Huxley, 2005) found low morale and high levels of stress (particularly among men), with over two thirds of ASWs experiencing a high level of emotional exhaustion. This workforce was more vulnerable to common mental health problems, with 43% at the threshold for depression and anxiety. They were more dissatisfied and more likely to want to leave their job, with a quarter having clear plans to leave. There were physical health impacts, particularly

among males, and a high level of burnout (exhaustion from excessive demands on energy and personal resources) with depersonalisation in relation to people who use services being more common. Fifteen years later this remains the case. There are substantial pressures including workload, complexity, the effects of austerity and social issues all of which affect morale, recruitment and retention. The inability to meet service users' needs affects stress and morale (CQC, 2018; Skills for Care 2018).

Finding a hospital bed for those liable for detention is consistently identified as the most problematic practical aspect of the assessment, even though this is not actually part of the AMHP's duties (Department of Health, 2015 para. 14.77). AMHPs report feeling vulnerable due to isolation, exposure to violence and aggression and lone working (Bowers et al., 2003; Coffey et al, 2004; Hudson and Webber, 2012) with the absence of a lone working policy being a concern in some areas (Department of Health and Social Care, 2019; Stevens et al., 2018).

The concept of emotional labour has been used to further explain and explore the ways in which AMHPs process intensely powerful emotions and feelings whilst managing individuals' and families' stress and trauma, co-ordinating complex assessments and containing individuals and their families while they wait for other professionals and agencies to offer the necessary resources and support (Hudson and Webber, 2012). The emotional impact of detention can be experienced as guilt, although the lack of beds and having to

walk away and leave a person in a situation of risk is equally problematic (Morriss, 2015). The social control function of the role has been explored within a context of 'dirty work', explained as the lack of opportunity to help or to do anything for someone in a therapeutic sense and, instead, having to do something to them in a coercive sense (Hughes, 1971). Difficult and 'dirty' work concerns the lack of beds, the complexities of coordination (including the lack of availability of the police), the act of detention, the lack of legal knowledge of some colleagues, being 'shouted at' by Accident and Emergency (A&E) staff due to the lack of transfer beds and facilities. Quirk et al. (2003) likened this aspect of the work to the morally dubious and anomalous nature of the 'policeman/executioner'. Conversely, crisis intervention and avoiding hospitalisation were seen as therapeutic work (Morriss, 2015).

Although AMHPs may believe that the person needs to be in hospital they are also aware that the wards are often bleak and sometimes dangerous places to be. Morriss (2015) and Webber (2016) suggested that AMHPs are seen to provide only a 'sectioning service' at the expense of therapeutic work. The Care Quality Commission's Chief Executive spoke of a service where 'control and containment are prioritised' over treatment and care (Care Quality Commission, 2016).

The emotional demands of carrying out statutory work are often unacknowledged and unrewarded. AMHPs often do not feel valued by their managers, with support more likely to come from other AMHPs,

with not all AMHPs receiving individual supervision and with stress and anxiety not being sufficiently acknowledged by managers (Gregor, 2010). The 'emotional challenges' have been recognised as ranging from 'horror' (around the detentions and loneliness) to the 'buzz of the job' (within the context of providing good care in challenging circumstances) (Hurley and Linsley, 2006). In parallel, AMHP work has also been viewed as prestigious (Gregor, 2010; Morriss, 2015) and encompasses a sophisticated use by AMHPs of emotion in the fulfilment of their role (Vicary, 2021).

Albeit first suggested in the mid-1990s, when there was a suggestion that probation officers undertake the work (Huxley and Kerfoot, 1994), the change from ASW to AMHP from 2007 occurred within the context of increasing numbers of detentions, the rising shortages of ASWs, an ageing and depleting workforce and the need to make appropriate use of relevant skills that were already available in the workforce (Laing, 2012; Coffey and Hannigan, 2013; Huxley et al., 2005; Mental Health Act Commission, 1999). Further, the creation of the AMHP role was a response to ASWs' high levels of stress and burnout (Huxley et al., 2005 Evans et al, 2005) and the notion that they were difficult to recruit (Audit Commission, 2008).

The broadening of the AMHP role to include other non-medical professionals created mixed views and some unease (Jackson, 2009; Rapaport, 2006; Jones et al., 2006). Concerns were expressed that it would compromise the unique knowledge and value-base that promoted

anti-oppressive and anti-discriminatory practice and would not be sufficiently independent of medical influence, thereby weakening people's safeguards at such a critical time (Bartlett and Sandland, 2003; NIMHE, 2006). Early reviews questioned the extent to which nurses could promote a social perspective (Rapaport, 2006) and mental health nurses highlighted potential challenges in balancing medical and social roles, where independence from medical colleagues may mean crossing into 'social work territories' and values, creating tensions and identity confusion (Coffey and Hannigan, 2013).

It was feared that clinical team collusion might increase (at the expense of the rights of people being assessed) as it could intensify the power of the consultant psychiatrist and the biomedical perspective (Nathan and Webber, 2010). The increased legal responsibility and accountability might potentially be difficult for nurses to shoulder and a significant concern for nurses has been that this type of statutory work would damage therapeutic relationships (Holmes, 2002; Laing, 2012; Knott and Bannigan, 2013; Coffey and Hannigan, 2013; Hurley and Linsley, 2006). On the other hand, the AMHP role could be seen as a new workforce opportunity that would be welcomed by health professionals as a step away from medicine which increases autonomy and confers additional prestige, as it was viewed within social work (Coffey and Hannigan, 2013; Stone, 2019). The Mental Health Act Commission (2003) recommended that the potential loss of the particular social work perspective must be countered by stringent training requirements.

Possible connections have been explored between the regulated profession to which an AMHP belongs, their experiences of the role and the ways in which they carry out the work. Bressington et al. (2011) explored differing professional viewpoints and levels of knowledge held by social workers and nurses during training concluding that, initially, social workers had a greater understanding of the role but, on completion, both groups demonstrated similar levels of learning. They suggested that alignment to the 'medical model' does not of itself prevent understanding of the concepts required to practice as an AMHP.

Stone (2018) explored the differences between social workers and nurses, and the ways in which socialisation through AMHP training has an impact on professional values, principles and paradigms. AMHPs' decisions around least restrictive options and risk may differ according to the professional background of the AMHP but this is related to a variety of individual subjective differences, experience, human agency and individual construction of risk rather than necessarily being about professional background. In contrast to the stereotypes, nurses were not preoccupied with medication in their risk assessments, while social workers seemed more focused on medication than anticipated. Social workers did not highlight social factors to a greater degree than nurses in their assessments and all participants demonstrated their adherence to the principle of least restrictive practice when looking for

proportionate alternatives to detention. Overall, the human rights approach, social perspective and specific value base does appear to have been retained, regardless of professional background (Buckland, 2016; Dixon et al., 2019; Laing et al., 2018). The fundamental concern about the professional's background only matters in two respects: firstly, that of an attribution or the quality or characteristic of an individual, and secondly the capacity to manage emotions in the fulfilment of the role (Vicary, 2016). This research concluded that it is a person's attributes that attract them to the role.

Overall, AMHPs emphasise that their professional value base is unique but aligned to the social work professional value base. This is founded on anti-oppressive and anti-discriminatory practice as well as the requirement to challenge where necessary (Morriss, 2015; Gregor, 2010). They also have a propensity to act as a 'brake' on clinicians' decision to detain (Peay, 2003, p.46). AMHPs described a unique form of practice wisdom, expressed as 'the way that you think', and report that becoming an AMHP is a rite of passage, with the worker achieving a higher status arising out of the additional 'mental power' and reflective practice required to manage the complexity and ambiguity of the work.

The work is seen as prestigious and higher-status, requiring advanced skills and the ability to manage very complex situations (Gregor, 2010). The 'best personality type' for the work is to be 'strong, assertive and able to challenge doctors' (Morriss, 2016 p.714).

Ideological differences between health and social services has led to communication being defined in terms of a struggle for control with AMHPs occasionally deliberately using their power in Mental Health Act Assessments to minimise the influence or dominance of the 'medical model' (Colombo et al., 2003; Rabin and Zelner, 1992). AMHPs consider their use of power in a way that distinguishes them from other professionals at Mental Health Act assessments and their unique role in these assessments has been considered in these terms (Gregor 2010; Morriss 2015; Buckland 2016). The lack of resources renders AMHPs' power and independence 'illusory' in that it has always been dependent on the development of community care and the availability of resources (Prior 1992, Quirk et al., 2003).

Within the broad range of research literature, AMHPs have identified significant motivating factors to undertake the work as:

- Career progression
- Independence
- Further training
- Professional development and status
- A clearer professional role within multidisciplinary services
- The opportunity to 'sensitively' apply the power and authority of the AMHP to complex real-life situations
- Enhanced job security
- Mental Health Act assessments as contained pieces of work

Some value the Mental Health Act assessment as a contained piece of work with a high degree of professional discretion and giving scope to exercise independent judgement and authority in a time-limited intervention which is emotionally and professionally rewarding and an opportunity to resolve crises for individuals and their families (Watson, 2016; Gregor 2010). Gregor (2010) also found that a common motivation for AMHPs undertaking the work was 'contractual obligation', in that it is usually a requirement of employment and career progression for local authority social workers whereas this is not the case for nurses.

As indicated above, the widespread shortfalls in the recruitment and retention of AMHPs has been a longstanding problem (Mental Health Act Commission, 1999; Huxley et al., 2005; Department of Health and Social Care, 2019). The most recent data from the Department of Health and Social Care and Skills For Care (2021) does however suggest a small increase to a headcount of 3,900 AMHPs who are approved by local authorities from the 2019 survey (Skills for Care, 2019). Previously, the Association of Directors of Adult Social Services (ADASS 2018) snapshot survey indicated that there were around 3,250 authorised AMHPs in England which had been a 17% drop in AMHP numbers from the previous survey. At the same time there are increasing numbers of applications for detentions in England under the Mental Health Act (NHS Digital, 2020).

Despite this, uptake of non-social work AMHPs has been limited. Following the revisions to the Mental Health Act 1983 few, if any, occupational therapists took on the role and no psychologists expressed an interest (NIMHE, 2008). There was no influx of nurses into the new role as had been anticipated (Rapaport, 2006; Campbell, 2010; Bailey and Liyanage, 2012; Bailey, 2012).

Following the introduction of the 2007 amendments to the 1983 Act, an informal survey of national AMHP local authority leads (Bogg 2011) found that 72% of local authorities had not extended their recruitment of AMHPs to non-social workers. To date, registered social workers make up the vast majority (95%) of the AMHP workforce with 4% registered nurses and less than 1% occupational therapists. Over half (59%) of local authorities employ only social workers (Skills for Care, 2020). Only one psychologist was found to have been approved to undertake the role (NHS Benchmarking and ADASS, 2018). The majority of AMHPs are employed in the local authority sector (80%), 15% in the NHS and 4% are agency and freelance. Around two thirds (65%) of AMHPs combine their role with another role while around one in four AMHPs (24%) act solely as an AMHP. The remainder are not primarily or regularly working as an AMHP. Only 15% of AMHPs work out-of-hours, for example in emergency duty teams (EDT) (Skills for Care, 2021).

The AMHP role is often not attractive to nurses, occupational therapists and psychologists for personal, cultural and structural reasons (Stevens et al., 2018). Nurses and occupational therapists experience the following issues: structural barriers affecting access to training; contractual agreements with balancing the AMHP and nursing role creating conflict (the AMHP function is a local authority responsibility); and disincentives around equal or competitive salaries (Bogg, 2011; Stone 2019; ADASS, 2018; Stevens et al., 2018).

Uptake of occupational therapist AMHPs has remained low. There is some coherence and overlap between the respective value bases of social work and occupational therapy and it is more likely that structural issues, rather than incongruent values, are impeding uptake (Knott and Brannigan, 2013). The small number of occupational therapists who have qualified as AMHPs have not always felt valued and the pressures arising from the nature of integration in mental health services have been noted (Morriss, 2015; Woodbridge-Dodd, 2018). Explanations for the low uptake by clinical psychologists are sparse but one suggestion is that using compulsion would adversely affect a relationship which rests on a basis of informed consent, trust and disclosure rather than acting as an 'agent of the state' of whom people are very wary (Holmes, 2002).

AMHP services have more recently been undergoing transition and reorganisation and there is an increasingly wide variation in the models of delivery of AMHP services in England (ADASS, 2018).

Models include teams dedicated only to Mental Health Act work from daytime (with support from emergency duty teams outside these hours) through to 24-hour services. Some 'hub and spoke' models have part-time AMHPs who support an assessment rota alongside their substantive role. AMHP services can also be supported by sessional or independent AMHPs to be called upon when needed (ADASS, 2018). Having non-integrated teams makes the work more isolating (Stevens et al., 2018).

It has long been recognised that the AMHP workforce is ageing (Evans et al., 2005; ADASS survey, 2018; Department of Health and Social Care, 2019; Skills for Care, 2021). Current estimates are that 33% of AMHPs are over 55 compared to 23% of social workers (Skills for Care, 2020). The AMHP role continues to have a higher proportion of people identifying as male (27%) compared to social workers overall (18%). Recent research suggests that 73% of social workers identified as being of White ethnicity and 27% of Black, Asian, mixed or minority ethnicity. AMHPs are less ethnically diverse than social workers overall (with 21% recorded as having Black, Asian, mixed or minority ethnicities) (Skills for Care, 2021). Concerns have therefore been expressed about the age and lack of diversity within the AMHP workforce – particularly given the specific role in reducing discrimination and supporting a human-rights led approach for people being assessed or detained (Department of Health and Social Care, 2019).

The Mental Health Act is known to disproportionately affect some groups and to indirectly discriminate (Department of Health, 2015). In the year to March 2020, Black people were more than 4 times as likely as White people to be detained with Black Caribbean people having the highest rate of detention out of all ethnic groups (NHS Digital, 2020). This again highlights the ways in which the AMHP workforce could be more aligned with the people it works with in terms of culture, race and ethnicity and to understand the effects of discrimination upon such groups (Department of Health and Social Care, 2019). The independent review of the Mental Health Act was commissioned by the government as an acknowledgement of the inequalities that exist for people from minority ethnic groups in terms of access to treatment, experience of care and quality of outcomes (Department of Health and Social Care, 2018).

People with lived experience of Mental Health Act assessments:
Review of the literature

The voice of people with lived experience within research relating specifically to Mental Health Act assessments and ASW/AMHP practice is limited, if not 'completely lacking' (Akther et al., 2019). Buckland (2020) undertook a scoping review of the qualitative literature relating to those who fall under the scope of Mental Health Act assessments. This included the person being assessed, friends and relatives, AMHPs and doctors. The literature, however, conflates detention under the Mental Health Act in hospital with assessment under the Mental Health Act and there is also a specific research gap around assessments not resulting in detention (Buckland, 2020). This, in itself, is indicative of the comparative value assigned to different types of evidence (Barnes et al,, 2000). More generally, people have reported different levels of understanding about the difference between 'voluntary' and compulsory admissions, with some experiencing coercion as part of an informal admission (Manktelow, 2002).

Previous literature reviews relating to a person's experience of assessment and detention (combined) have identified a lack of autonomy, a lack of information and involvement in decision-making and a distinct lack of good, therapeutic care (Katsakou and Priebe 2006; Seed et al., 2016; Akther et al., 2019).

The significant emotional impact of detention, sometimes experienced as a highly traumatic event, has been acknowledged (Katsakou and Priebe 2006; Seed et al., 2016; Akther et al., 2019). In parallel, people report ambivalence towards involuntary hospitalisation: although involuntary admissions are on the whole strongly associated with coercion and trauma, between 33% and 81% of patients have been found to retrospectively regard their involuntary treatment as justified and/or beneficial. The wide span here is due to studies having inconsistent methods or research aims in a variety of contexts. There are very few, if any, validated instruments to assess people's attitudes as to the justification of their (involuntary) admission and treatment, or their perception as to benefits from it (Priebe et al., 2009; Katsakou and Priebe, 2006).

All these issues clearly have relevance for AMHPs' decision-making and are bound to create difficult dilemmas for AMHPs, especially when there is a lack of alternatives to involuntary hospitalisation and inpatient beds are dangerously scarce. Buckland (2020) also recognises that the real threats and potential traumas of hospital environments have a unique prominence in the mental health user and survivor literature. Further, she highlights the ways in which research by and with users and survivors shows relationships with professionals to be deeply unequal and to have the potential to be incredibly positive or incredibly damaging on personal and emotional levels and in terms of future consequences and relationships. Mental Health Act assessments and their wider contexts are often deeply unequal in their power dynamics and as such are at odds with a broader policy rhetoric of collaboration and recovery (Buckland, 2020).

Approved Mental Health Professionals:
Findings from the survey

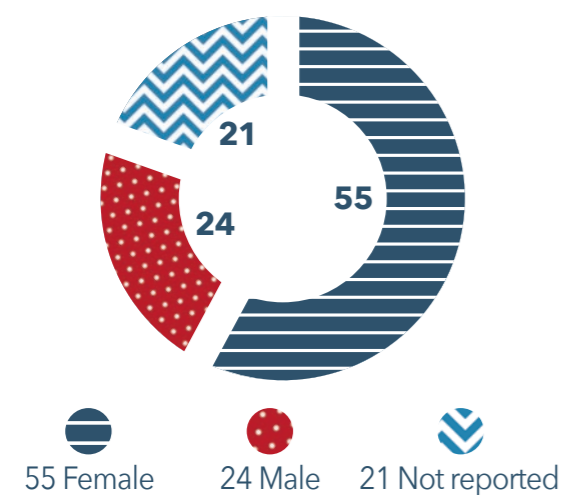### Survey respondent demographic data

The AMHP survey received 258 completed returns.

Regulated professional role

We received survey responses from 247 social workers (95.74%), 10 nurses (3.87%), 1 occupational therapist (0.39%) and no clinical psychologists. This is in line with the national demographic which is 95% social work, 4% nursing and 1% occupational therapy (Skills for Care, 2021). All were based in England apart from one who identified that they were based in Wales.

Gender % Reporting

| 55 Female | 24 Male | 21 Not reported |

The declared gender for AMHPs was 55% female (142), 24% male (62) and 21% (54) did not share this information. From those who reported their gender, this would equate to 70% female and 30% male. The national representation is 73% female and 27% male making this survey generally representative of the AMHP population nationally (Skills for Care, 2021).

AMHP: What is your Ethnicity? % Reporting
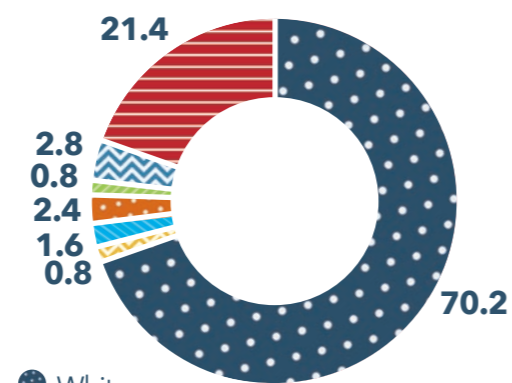
- White
- Not reported
- British
- Other ethnic group
- Black/African/Caribbean/Black British
- Asian/Asian British
- Mixed/Multiple ethnic groups

70% described their ethnicity as White, 2.8% Asian/Asian British, 2.4% Black/African/Caribbean/Black British, 21% did not declare their ethnicity and the rest were from mixed/multi-ethnic backgrounds or other ethnic groups. According to national data, 79% of AMHPs are White and 21% from racialised communities (Black, Asian, mixed or minority ethnic backgrounds) (Skills for Care, 2021). This data is not disaggregated further.

For comparison, statistics from a survey in 2018 indicate that for people who are assessed under the Mental Health Act, 76% were from a White British background and 9% were from a Black British background with the remainder being from an 'Other or Mixed Race' category (Care Quality Commission, 2018).

Age groups

Age in years

34% of AMHPs were in the 41-50 age range, 35% were in the 51-60 range and 7% were over 60. Of those that responded 76% were over 40, in line with the national picture (Skills for

Year first approved as an ASW/AMHP

Care, 2021) where our representation confirms the ageing demographic of the AMHP workforce.

We asked our respondents when they were first approved and we had representation across a broad range with the majority having been approved within the last decade. Nurses' AMHP qualifications range from 2012 to 2021 and the occupational therapist AMHP respondent qualified in 2016, which would be in keeping with the 2007 revisions to the Mental Health Act (1983).

Academic award from qualifying AMHP programme % Reporting

- MA or MSc
- PGDip
- PgCert
- ASW
- MWO
- Don't know

We asked AMHPs which academic award they gained as part of their AMHP qualification. The majority had qualified as ASWs, a qualification that was not embedded within an accredited university qualification. The second largest group qualified with a Postgraduate Certificate followed by a Postgraduate Diploma and the smallest group qualified with a Masters degree. One person qualified as a Mental Welfare Officer, the precursor to the ASW role, and a small number did not know.

AMHP workforce details

Professional background represented in the AMHP workforce
(392 responses)

Social Worker	Nurse	Occupational Therapist	Chartered Psychologist	Don't know
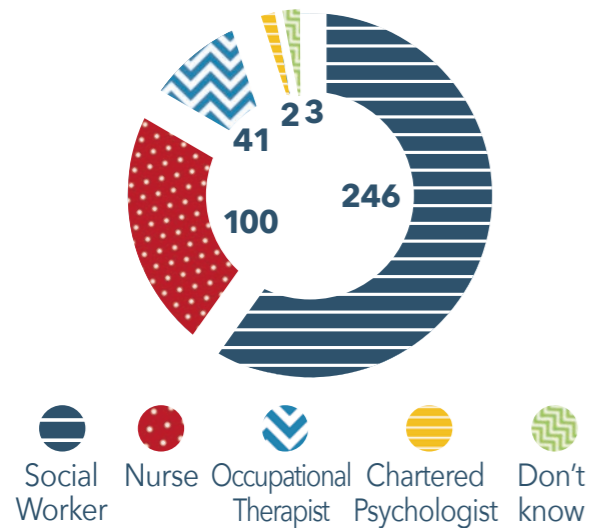
We asked which professional backgrounds were represented in the AMHPs' own workforce. They were able to select more than one professional background and the findings indicate that social workers are the predominant profession within AMHP workforces, but also that many respondents also have experience of working with AMHPs from other professions.

The following graph indicates the number of professions selected by each respondent. 119 selected only 1 profession, 78 selected 2, 27 had three professions represented whilst 4 respondents selected 4 different professions.

Professional backgrounds represented in the AMHP workforce
(Number of selections made by each respondent)

1 profession	2 professions	3 professions	4 professions
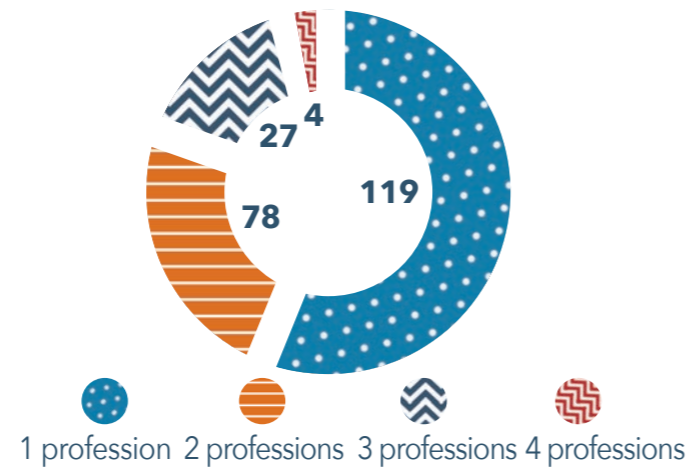
We asked AMHPs to confirm their current employer. 80% were employed by a local authority, which is exactly in line with the current national statistic, and 16% were employed by a mental health Trust, in line with the 15% of the national picture. Our sample had 1% self-employed or independent AMHPs which compares with 4% in the national demographic (Skills for Care, 2021). The same national survey indicated that 38% of local authorities also employ sessional AMHPs to cope with peaks in demand.

Who is your current employer?
(% total)

Local Authority	Mental Health NHS Trust	Self-employed independent AMHO	Other

Social workers work mostly for a local authority (81%), with 24 (10%) working for a Mental Health NHS Trust, 1 employed by a local authority but seconded to a Mental Health NHS Trust, whilst 2 were self-employed and 1 employed by a local NHS Trust (not mental health). Of the 10 nurse participants, 4 stated that they work for a local authority and 6 for a Mental Health NHS Trust. The occupational therapist stated that they work for the local authority.

Is working as an AMHP your primary role?
(% responses)

No	Yes
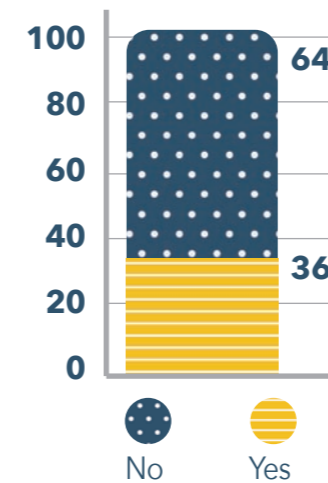
Given the historic difficulties for AMHPs' workload balance, the recent workforce reorganisations and increasingly wide variation in the models of delivery of AMHP services in England, we wanted to understand whether AMHPs were in primary (full-time) roles or whether their AMHP role was shared with other responsibilities (mixed role AMHPs). 36% of respondents stated that they were full-time AMHPs which is above the national average of 24%. Part-time or mixed role AMHPs made up 64% of our sample which is lower than the 74% national average (Skills for Care, 2021).

How would you define the remainder of your role?
(% total)

Care Act activities	Care coordination	Case management
Duty/Triage worker	Safeguarding	Other
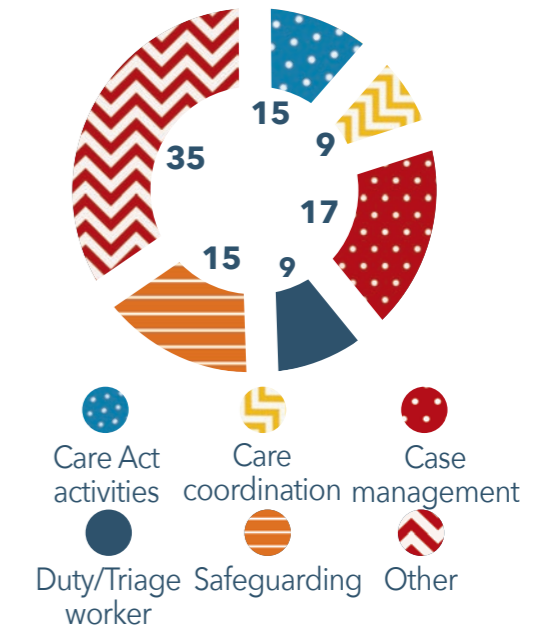
Where AMHPs were not full-time, they outlined a range of other responsibilities including Care Act activities, safeguarding, case management, duty or triage work and care coordination.

AMHP service configurations
(% total)

● Dedicated AMHP team which considers and undertakes all assessments

● Mixture of dedicated AMHP service and AMHPs who have other duties

● AMHPs who have other roles and work on a rota basis
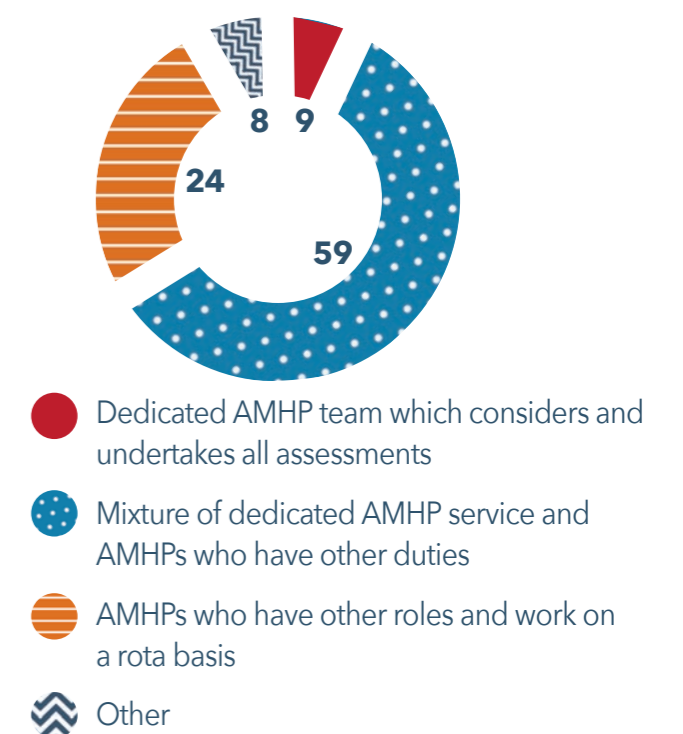
● Other

Duty rota models ADASS (2018) survey
(% total)

Central AMHP 'hub' only · 'Hub and spoke' model · Locality teams · Other models

AMHP respondents described the ways in which their services operate in a variety of models. Only 9% worked in a fully dedicated AMHP team whilst 24% had other roles and worked on a rota basis. 59% worked in a service providing a mixture of dedicated AMHP and other duties. Although not directly comparable, the national statistics from the ADASS (2018) survey did outline different models of duty rotas, suggesting that 19% of areas had a central AMHP 'hub' only, 36% had developed a 'hub and spoke' model (with a mix of full-time and part-time AMHPs), 16% had locality teams and the remaining 29% had other models.

AMHPs and professional identities

To begin to explore AMHPs' views on their own professional identity and what being an AMHP means to them, we asked whether they viewed it as a profession, a qualification, both or something else.

Do you think being an AMHP is a:
(% total)

Profession · Qualification · Both · Other
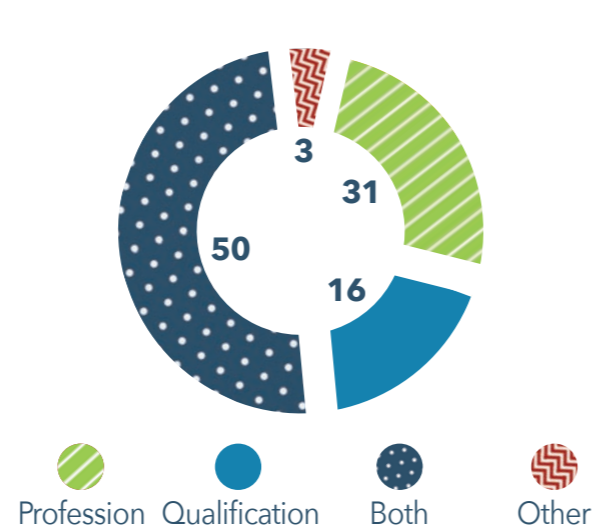
Only 16% see the AMHP role as a qualification alone so we were keen to understand the elements of professionalism that paralleled this. To explore subjective views we asked respondents whether they see their AMHP role differently to their regulated professional role (social worker, nurse or occupational therapist). We were seeking to understand any aspects of divergence as well as areas of overlap in the ways in which the AMHP role aligned (or not) with their regulated professional role.

Do you view your AMHP role any differently to your regulated professional role?

Four fifths (80%) of social workers did see their AMHP role as being different to their regulated professional role compared to one fifth (20%) who did not. The perceived differences were articulated in numerous ways. Overall, the main areas of difference were where the AMHPs perceived it as a specialist role requiring additional knowledge and skills, with greater power and status and with requirements over and above their professional social work role. The responses highlighted a perc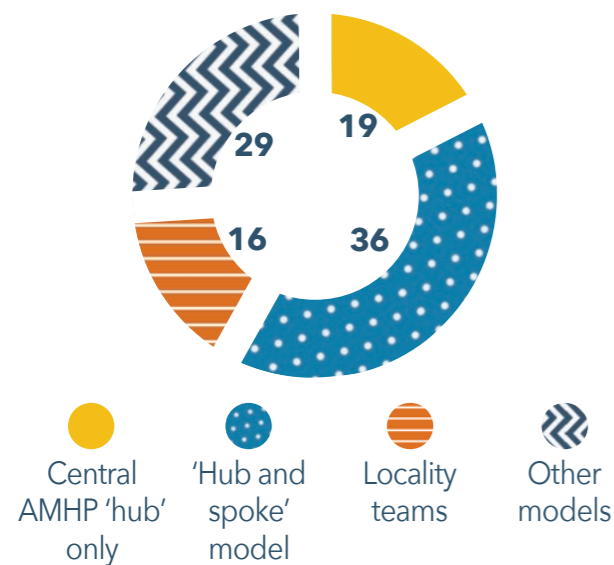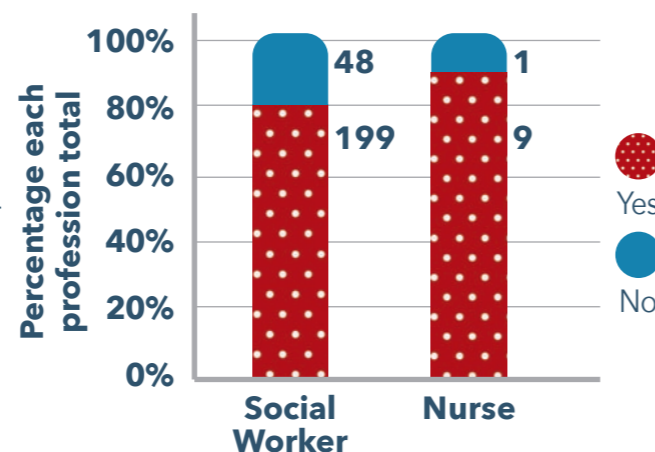eption of greater autonomy, independence and decision-making latitude. The role was also often associated with short-term interventions and distinct statutory work with greater interface with legislation. A few respondents mentioned that they also assess people outside their usual practice specialism or service area[3]. Alongside this, however, sits a perception of greater risk (both personal and professional), personal responsibility and accountability. To illustrate the distinctions, respondents highlighted that:

"It is a specialist role that focuses [at the point of mental health crisis] on ensuring that the law is followed and [people's] rights are protected. The role requires specific knowledge and expertise"
(social work AMHP)

"It feels a bit "special forces'' (if that's not too grandiose) with regard to "standard" social work. It feels like we go to places and make decisions about things that "regular" social workers don't or can't make. The fact that we are personally liable for our own decisions is part of this, and one I personally relish"
(social work AMHP)

Of the 20% of respondents who reported no difference between the roles they suggested that the skills, knowledge and professionalism are transferable and applicable to each role. Both roles are intrinsically linked with upholding human rights and focusing on liberty. Being an AMHP was described as core traditional social work practice which was not different to, but just an extension of, their social work identity:

"I believe that a human rights focus should be at the core of social work. I see my AMHP status as indelibly linked with my social work identity. As a matter of course I will always refer to myself as a social worker who is also an AMHP"
(social work AMHP)

"I am still a social worker as well as being an AMHP. Completing my AMHP training was something I view as continuing my professional development in mental health social work"
(social work AMHP)

[3] The ADASS (2018) survey made reference to AMHPs being based in particular service areas, where 86% of AMHPs were reported to work in adult mental health services, 7% within older adults, 3% within children's services (albeit probably Emergency Duty Teams) and 4% within learning disabilities. This also illustrates the range of services and the broad range of requests for Mental Health Act assessments from these areas.

One area where there was some divergence in views was related to the alignment between AMHP and social work values with some believing there was synergy whilst others strongly suggested it was less so:

"Often being an AMHP is incompatible with what social work values are: [it is] discriminatory and oppressive. I believe social rather than health policies would help most people I see [...] Detention is traumatic. I frequently privilege the information of a family member over the person, [which is] necessary as part of society's intention to "contain risk" [which is] my de facto role as AMHP"
(social work AMHP)

To understand the perceived influence of each of the regulated professions on AMHP work we asked survey respondents to tell us how AMHP work is, in general, informed or influenced by the ethos and values of each of the regulated professions. We invited comments on any observed differences in the way different professions undertake the role.

AMHPs were asked to select all the professions that they thought had an influence on AMHP work. Respondents could select as many different professions as they wished and there was a strong response rate of 94%. The 231 social work respondents provided a total of 326 selections. Almost all (225) perceived that AMHP work was informed or influenced by social work. 54 (23% of social work

Do you think AMHP work generally is informed or influenced by the ethos and values of the following professions?
(Social Worker respondents - 231)
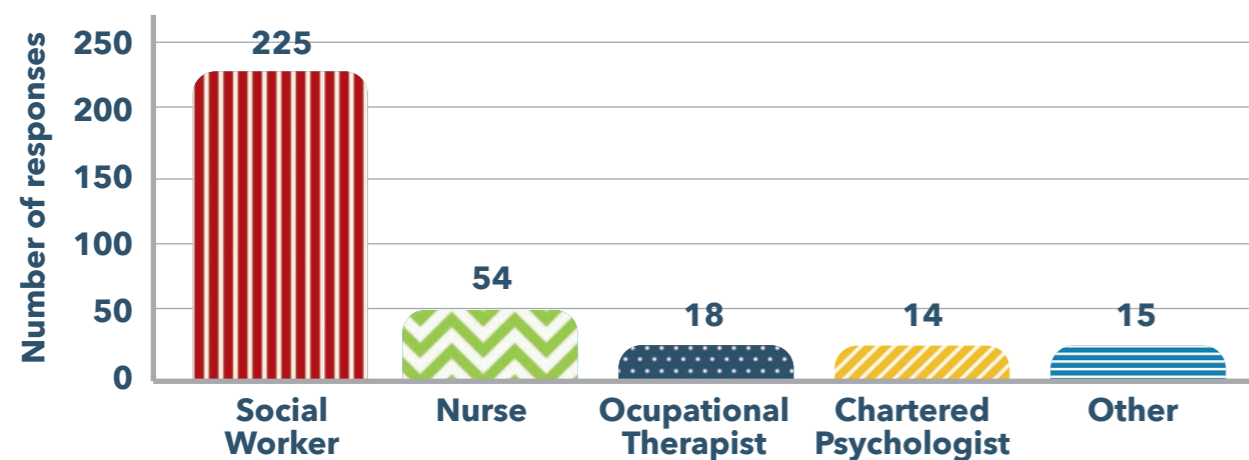
Do you think AMHP work generally is informed or influenced by the ethos and values of the following professions?
(Nurse respondents - 10)
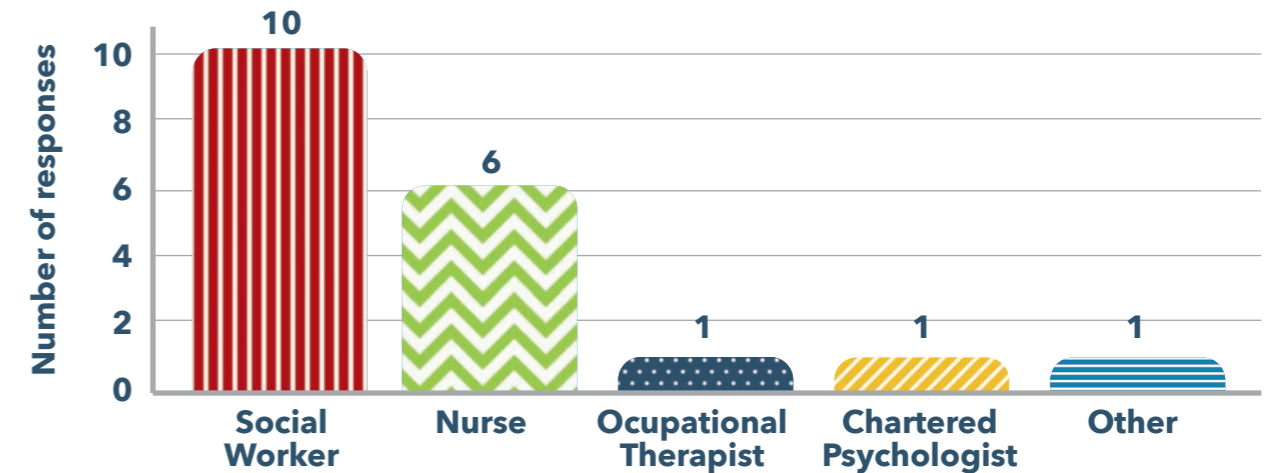
respondents) indicated a nursing influence, 18 (8%) occupational therapy and 14 (6%) psychology. The 6.5% of respondents who chose 'other' are explored in the qualitative data below.

All 10 nurse AMHPs identified social work as informing or influencing AMHP work with 6 also choosing their own profession in the same regard.

What social work brings to the AMHP role

The responses indicate that AMHPs draw on the influences of all professions to a greater or lesser degree. Social work is seen to have the greatest influence with a 'natural correlation' due to the 'strong social model approach', an 'awareness, understanding and need to challenge multiple forms of discrimination', a 'strong focus on person-centred practice', where 'social work values and professional views come to the fore' and

where 'there is a strong human rights based approach'. There was an acknowledgement of the fact that the AMHP workforce is led and strongly influenced by social workers. The stress was laid upon the continuity from ASW training and practice and the maintenance of the statutory competencies which underpinned both roles. This legacy, along with the symmetry between the core values of the profession and the legislative frameworks was reiterated throughout.

What social work brings to AMHP work was articulated in numerous places within the survey and included the social model of disability, social perspectives, seeing the person holistically and having a viewing point which is distinct from psychiatric and clinical approaches (although some still highlighted the crossover of knowledge). For the majority, anti-oppressive practice, human rights perspectives and the inherent advocacy of the role represented the reasons that

AMHP work was influenced by the values of social work:

"Detaining someone is the most oppressive thing you can do. My professional ethos and values support me to see this as a last resort"
(social work AMHP)

"AMHP training focuses on the social perspective, social justice and rights and is central to my AMHP practice"
(nurse AMHP)

"As a nurse AMHP I practice with the values of least restrictive options always being explored, value and include family input, advocate for the patient [and] acknowledge that all areas of a person's life can impact on their mental health"
(nurse AMHP)

There were some observations that non-social workers' lack of practice knowledge around social care and legislation other than the Mental Health Act may be limiting factors. A small number of social work AMHPs suggested that, in their experience, nurses do not always recognise safeguarding issues or aspects of child criminal exploitation and that 'NHS staff are not decision-makers when it comes to the Children Act'. There was also an observation from a nurse AMHP that social workers have a 'better knowledge of support packages funded by local authorities'. This was in keeping with a perception elsewhere that a lack of knowledge or access to community support compromised nurses' ability to explore the least restrictive alternatives to hospital where they have no social care experience. One or two social work respondents observed that nurses would refer to a social worker rather than do it themselves. It was suggested that without this practice knowledge nurses may be limited to 'health options' and a focus on medication. It is not altogether clear if this was a feature of the way services were configured or if it arose from the knowledge and training of the differing professions.

There were some perceptions expressed about core differences in values and approaches such that one AMHP believed that:

"There is something about a social worker that makes us advocate more for a person [...] Our profession is about engagement with the person at the centre of the process. The other professions do things to people"
(social work AMHP)

There was a suggestion from a social worker that the social perspective was stronger for nurses because it is a new approach to their practice, however, this was coupled with the idea that they can sometimes struggle to maintain independence in the role. There were a small number of suggestions that social work AMHPs may be better at withstanding pressure, for example around not accepting a referrer's request for a Mental Health Act assessment where it is unnecessary, although this was strongly countered elsewhere by a nurse AMHP.

Occasionally, nurses' observations about social workers' practice indicated that it was not always necessarily effective:

"High legal literacy, but can [this] sometimes be at the expense of clear communication with the individual and their network"
(nurse AMHP)

What other professions bring to the AMHP role

Nurse AMHPs

Views about the influence of the nursing profession on AMHP work were articulated although, due to the lower numbers of nurses in the survey, our respondents' experiences in practice were to some degree limited. The influence from nursing was perceived to arise from medical knowledge and models, particularly in relation to medication, although some respondents recognised that nurses bring other perspectives and values of care and compassion that afford an opportunity for the AMHP role to be enhanced:

"Nursing [has] values around kindness, preserving safety [and] collaborative working"
(social work AMHP)

"Nurses apply social perspectives but are also more often able to bring psychological and medical perspectives"
(social work AMHP)

Some nurse AMHPs' practice observations were offered:

"My knowledge of health trust pathways and processes is a strength. The holistic training provided to nurses is also a significant benefit as I feel that I have a broader foundation of assessment skills"
(nurse AMHP)

"My experience as a mental health nurse helps me evaluate risks and benefits of hospital treatment"
(nurse AMHP)

Opinions were expressed in relation to the values of nursing:

"I do […] believe that other professionals can and do carry the same values"
(social work AMHP)

"AMHP work historically links to social work ethos and values, but social work does not retain a monopoly of such now. [There are] common themes of person-centred [and] strengths-based practice, co-production, valuing rights and autonomy etc"
(social work AMHP)

Some responses suggested individual attributes were the same:

"On the whole, [nurses are] professional, committed workers who want the best least restrictive outcomes for people who use services and their families" (social work AMHP)

Nurses' views of the influence of their own profession included:

"Less knowledge about social services and alternatives to health-based interventions" (nurse AMHP)

"Legal literacy is lower and therefore learning curve steeper" (nurse AMHP)

"Better understanding of mental disorders and treatments likely offered in hospital" (nurse AMHP)

Occupational therapist AMHPs

It was acknowledged in the responses that occupational therapy AMHPs are rare. On the whole, responses painted a picture of little to no experience of this profession undertaking the role. Nonetheless, the limited responses did acknowledge the thoroughness of their approach and that there was a place for them in AMHP work:

"Occupational therapists have broad and varied training that would be beneficial to the AMHP role and AMHP practice" (dual registered nurse and social work AMHP)

Perceptions of the contribution from occupational therapy were understandably often hypothetical but it did appear that differences were seen to be less stark in relation to social work and occupational therapy (where professional values seemed more aligned) than with social work and nursing. Occupational therapists were understood to take a strengths-based and problem-solving approach, to promote independence and to address community alternatives to hospital – all attributes that lend themselves well to the AMHP role. However there was a recognition that because their number is small, few people value their perspective:

"[I'm] the only one in the service, so not having a massive influence" (occupational therapy AMHP)

Where occupational therapy's specific contribution came to the fore it generally concerned the functional, practical aspects of the role:

"For example, you often hear someone is non-compliant with medication: they cannot open their medication? Do they have the ability to distinguish between tablets? Is their sleep/wake pattern unusual meaning they miss medication?" (social work AMHP)

Psychologist AMHPs

There were limited experiences of working with psychologist AMHPs, although there was conjecture that as they would be knowledgeable about mental distress and different types of interventions this could be a positive. This expertise included the ability to help the person and work through trauma or generally exploring alternatives to medical perspectives. One respondent spoke of a potential incompatibility between the AMHP role and psychology due to the act of compulsion, but they balanced this within a context of the AMHP's statutory imperative to 'consider all the circumstances of the case'. Other comments made reference to professional traits and perceptions that psychologists may be more risk averse or patriarchal.

AMHPs' professional differences: Real or illusory?

Following the early debates within the literature around the AMHP role being opened to non-social workers, in many respects it remains a complex and, at times, thorny issue. A reading of our data suggests that mental health settings and their inconsistent (and in some areas controversial) approaches to integration significantly influence and inform ideas on the ground.

Some did frequently question non-social workers' ability to balance medical approaches:

"Social workers' training and background provide the balance to the medical model during assessments. The underpinning values of the other professions are still quite hierarchical and my experience has been that the majority of AMHPs from other professional backgrounds are less committed to anti-discriminatory and anti-oppressive practice and more willing to be swayed by authoritative medical professionals" (social work AMHP)

However, we heard some rejoinders from a nurse AMHP perspective:

"I don't believe the differences between nursing and social work are as great as social workers like to think they are" (nurse AMHP)

"Having worked alongside them [social workers] for years, I have absorbed some of their thinking and can talk the anti-discriminatory talk with the best of them" (nurse AMHP)

Hierarchy as a recurring theme

Organisational hierarchies (and the NHS and healthcare Trusts were frequently and resoundingly referred to as being hierarchical throughout the project) are seen to represent unshakeable organisational cultural influences. This linked very clearly to a robust assertion of the AMHPs' imperatives around independence, autonomy, power and capacity to challenge:

"It's about social factors and social workers are better decision-makers due to [their] independence from medical teams and NHS hierarchical structures"
(social work AMHP)

Many social work AMHPs made reference to the need (and capacity) to 'shake off the hierarchical structures' in their practice. One particularly strong comment focused on a fundamental difference regarding responsibility:

"My experience has been that nurses take less personal responsibility for situations. I am assuming [this is because] their training is much more team and hierarchy based. Nurses seem more able to walk away from situations saying they have done all they can do, and handing over to other services to take responsibility"
(social work AMHP)

Elsewhere, however, there was an acknowledgement that nurse AMHPs can maintain the independence that is required of the role and that they can assimilate AMHP professionalism:

"Many nurses now sound a bit like social workers in their understanding of the social model as distinct from the medical perspective which is reinforced by the hierarchy within the health service."
(social work AMHP)

One respondent recounted a nurse colleague being described by a doctor as a 'turncoat' perhaps suggesting that the nurse has somehow betrayed the health profession. It seems a fundamental point here, illustrated by the frequent return to the need for independence and challenge, that this issue might be less to do with nurses' knowledge and ability and more to do with relationships with the infrastructures and hierarchies of an organisation upon which many AMHPs direct their frustrations. Nurses recognised and responded to the critiques and opinions about the influence of hierarchies:

"[Social workers are] disparaging of other professionals - believing nurses to be subservient to medics"
(nurse AMHP)

One nurse did, however, 'appreciate social workers' sense of being apart from doctors' in their approaches to the work suggesting that nurses could follow suit.

AMHPS as independent, autonomous and individual

As their numbers remain so small within the workforce, it may be the case that views around non-social work AMHP work are still, at times, based on hypothetical rather than experiential knowledge. Where this experience existed, there seemed to be a recognition that differences are entirely individual and not based on the regulated professions:

"I don't think my comments are profession specific, more 'individual people' specific"
(occupational therapist AMHP)

"I have found that it very much depends on the individual's attitudes, work ethic, enthusiasm, knowledge etc. rather than their profession"
(nurse AMHP)

Challenges of the AMHP role

AMHPs were asked if they found any aspects of the work challenging and were invited to highlight which aspects were the most difficult. Here there were no differences between regulated professionals' experiences. The greatest and ever-present challenges are summarised in the box.

- Little or no alternative to detention (a situation which has worsened during periods of austerity and through the current pandemic)
- High number of assessments coupled with insufficient AMHP numbers leading to fatigue
- Report writing having to be done within time constraints leading to compromises to thoroughness
- Securing services out of area
- Long waits for services, the coordination thereof and the feeling of being "stuck in the middle"
- Others' lack of understanding of the AMHP role and a medicalisation of the situation
- Assessments with language barriers
- Staying abreast of the law, particularly in relation to the Mental Health Act and Mental Capacity Act interface
- Negotiating with doctors who are not invested in looking at alternatives and difficulties reconciling outcomes with the statutory guiding principles
- Time pressures and difficulty in being able to slow the process down
- The person not being as involved in the decision-making as the AMHP would wish (due to time and workload pressures)
- 'Invisibility' of the role and a lack of representation from within their services and beyond
- Compromised authority and independence: being perceived as a doctor's secretarial support or being subject to ward manager instruction (regardless of profession)

Practice challenges associated with additional stress were:

- Lone working and the feeling of working in isolation, especially "holding" situations when awaiting services or colleagues
- Other professionals' negative attitudes
- Levels of violence and risk
- Lack of recognition or respect from the organisation and senior managers
- Finding it difficult to make a decision where there is 'no good outcome'
- Emotional drain involving long hours, sometimes out of hours, and impacting on work/life balance
- Intensely emotive situations which are sometimes traumatic
- Depriving someone of their liberty whilst knowing the therapeutic benefit of admission is questionable
- Identifying with the family's distress
- Having no time to process the emotional impact of the decision
- Worrying about the 'right decision'
- Fear of repercussions if reports do not explain decision making sufficiently

AMHPs spoke of the burdens of the very nature of the work and of people's experiences:

"I am often plagued by the injustice of the circumstances [from which the person has] developed mental ill health (abuse or exploitation) which then lead me to detain [them] further adding to their feeling of worthlessness and injustice. I am often disturbed by the negative attitudes of other professionals"
(social work AMHP)

Overall, AMHPs clearly wanted to do the best for the people they were assessing but they were continually thwarted by the lack of services and resources. Many expressed worries that they were increasingly being asked to 'do more with less'. Some expressed fears that, at times, the system they worked in seemed on the brink of collapse with colleagues leaving through burnout and with an insufficient number of colleagues being trained. This was compounded by a feeling that they were often forgotten about in public policy discussions around mental health and in reforms of legislation.

Health and wellbeing

Given the ongoing association of stress and burnout with recruitment and retention we wanted to understand how AMHP work affected respondents' health.

We wanted to understand the source of the stresses and whether these remained consistent with the literature. In the survey, AMHPs were asked to what extent (if any) their AMHP work affects their physical, psychological, emotional and mental health. We asked them to rate these on a scale of 1 to 10 (with 10 representing 'a lot') and to explain their response.

To what extent does your AMHP work affect the following?
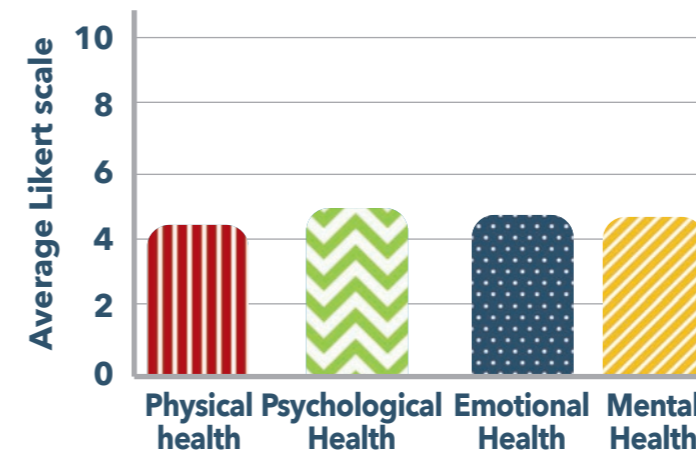
Responses to this question were spread fairly evenly but a slightly higher number highlighted the effects on their psychological and emotional health. Bearing the weight of responsibility for all aspects of the Mental Health Act assessment was highlighted as particularly difficult as was the conflict experienced with other professionals and organisations. The intensity of the work came through clearly and, for some, AMHP work felt like 'risky' work.

AMHPs frequently stated that there was an impact on their ability to achieve a reasonable work-life balance. Several mentioned childcare problems due to the long hours and (for some) the impact on family life was cited as a reason for ending their AMHP role in the near future. AMHP work led to poor eating habits, poor sleep prior to and following assessments, feeling physically drained, negative impacts on family life and a lowering of mood. Community assessments can mean there is no opportunity to take breaks and sometimes no toilets are available.

AMHPs spoke of feeling unsupported, undervalued and under-appreciated and this was compounded by poor or absent supervision opportunities which led to anger and frustration. A lot of people talked about the emotional aspects of the work in relation to emotional labour and trauma. A powerful account of AMHP work was as follows:

"It is a stressful role, so days I am on AMHP duty are usually the most exhausting physically and emotionally. We are often with people at their most distressed and at times alone with them in their homes […] Being party to and witness to distressed people being physically restrained or […] dragged away from loving and upset family members affects my wellbeing - it's not something I am comfortable with. My loved ones often tell me that after an AMHP shift I come home 'spaced out' and detached. It's not a role they think

is good for me, but I feel it's a role that no one can enjoy and it needs doing by compassionate and committed social workers so I want to continue to do it"
(social work AMHP)

The ability to continue to carry on with the role was an ongoing concern:

"I have gained knowledge and skills which help me but the level of stress and worry has continued and not got any better over the last two years since I was first warranted"
(nurse AMHP)

The difficulties affected all professions equally. Interestingly, and illustrative of the shared problems, one nurse AMHP found that:

"It is stressful when resources are not available. It can feel like we have all the responsibility and no power and are alone going against a tide of other agencies which lack understanding of the law or their duties"
(nurse AMHP)

Organisational uncertainty was referred to were one AMHP unexpectedly found the consistency of AMHP work something of a comfort:

"At a time when services were being reconfigured and teams splitting up, the straightforward aspect of the AMHP role, that is assessing people under the Act, was quite comforting"
(nurse AMHP)

Many identified that the most stressful and difficult part of the work was around the lack of ability to meet people's needs:

"I often feel frustrated, sad, anxious, tired after an assessment - especially when we have not been able to complete the assessment [or] get the required outcome […] Having to leave situations that feel unsafe can take its toll on the AMHP [creating] mental strain [and] anxiety"
(social work AMHP)

"Lack of beds is very stressful with the AMHP often holding responsibility for the client while a bed is identified. I have, at times, waited for up to 7 days for a bed to be identified"
(social work AMHP)

Here, and across the research project as a whole, the different aspects of full-time and mixed role AMHP work were raised and it was difficult to discern whether either was more or less rewarding or stressful:

"Sometimes it is difficult leaving your "day" job to go onto the Duty Rota […] especially at busy times and [with] pressures from your case load"
(social work AMHP)

Rewards of the AMHP role

Whilst some individuals expressed profound health impacts, there were also AMHPs who identified fewer health concerns and said that they enjoy their work. Again there was no difference between the regulated professions or with any other area. Where people did not feel affected, one or two mentioned the use of support networks that were part of this. Others enjoyed the challenges and experienced their professional autonomy to be a rewarding aspect of the role. Positive perceptions were generally allied to a satisfaction that the work can have good outcomes for people:

"I really enjoy the work. It can be interesting and it can allow creativity when trying to find alternatives to detention"
(nurse AMHP)

"Overall I find it a challenging, but rewarding role. I benefit from the autonomy of the role and having the power to intervene in a positive way"
(social work AMHP)

For those who stated that the role did not negatively impact upon them, they indicated that the independence, autonomy and mentally stimulating benefits of the role were a change from routine casework which served to mitigate the demands described above. Negative effects were further ameliorated by having good peer support, having a break from the AMHP rota or reducing the frequency of duty shifts. Some AMHPs thrive on challenges and their 'expertise' leads to a sense of accomplishment.

Leadership, support and supervision

We wanted to understand AMHPs' experiences of support and supervision. We asked AMHPs if they received professional supervision to which 69% answered yes, with 25% saying no and 6% choosing to leave this blank.

Do you receive professional AMHP supervision?
(% total)

6

25

69

● Yes ● No ⩗ Blank
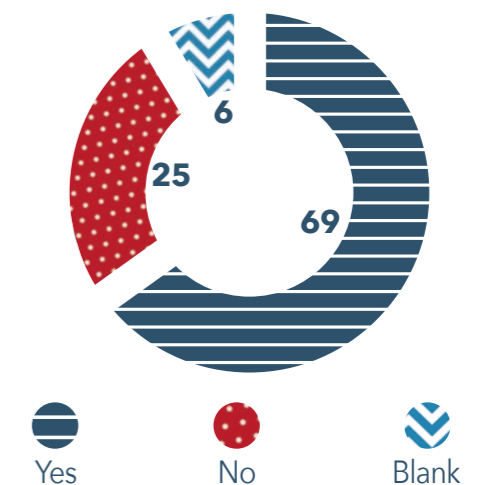
Drilling down into this data by profession, of the 231 social workers who responded 74% (170) answered yes but fully 26% (61) stated that they did not receive professional supervision. 9 out of 10 nurses and the occupational therapist indicated that they did receive supervision.

We then asked all AMHPs if they have a dedicated AMHP lead or AMHP manager. The majority (95%) stated that they did, with the remaining 5% answering no.

Do you have a dedicated AMHP lead/AMHP manager?
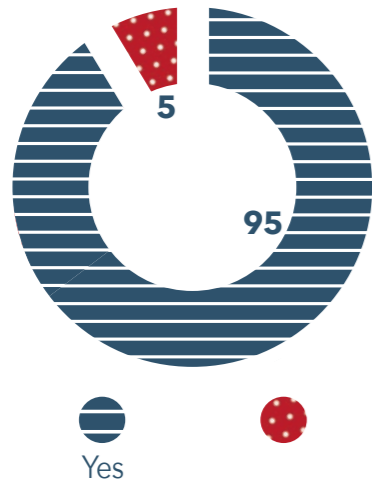
As would be expected, the vast majority of these AMHP lead/managers were from the social work profession (95%). 4% were nurses and 1% 'other' AMHP lead/managers.

We analysed the correlation between the professions of the AMHP lead manager and the AMHPs. Of the 233 social workers who indicated they had a dedicated lead/manager 97% (225) said their lead was a social worker. Of the remaining social worker AMHPs, 6 (3%) said they had a nurse manager, 2 had 'others' and 10 said that they had no lead/manager. The majority of nurse AMHPs (80%) had a social work lead/manager, one (10%) had a nurse lead/manager and one (10%) had no lead/manager. The occupational therapist was managed by a nurse lead/manager.

We asked all AMHPs which of the options outlined in the table below were the most welcome or effective support strategies. They were asked to rank these in order of importance with 1 being the most welcome and 5 being the least welcome.

Which are the most welcome or effective support strategies?
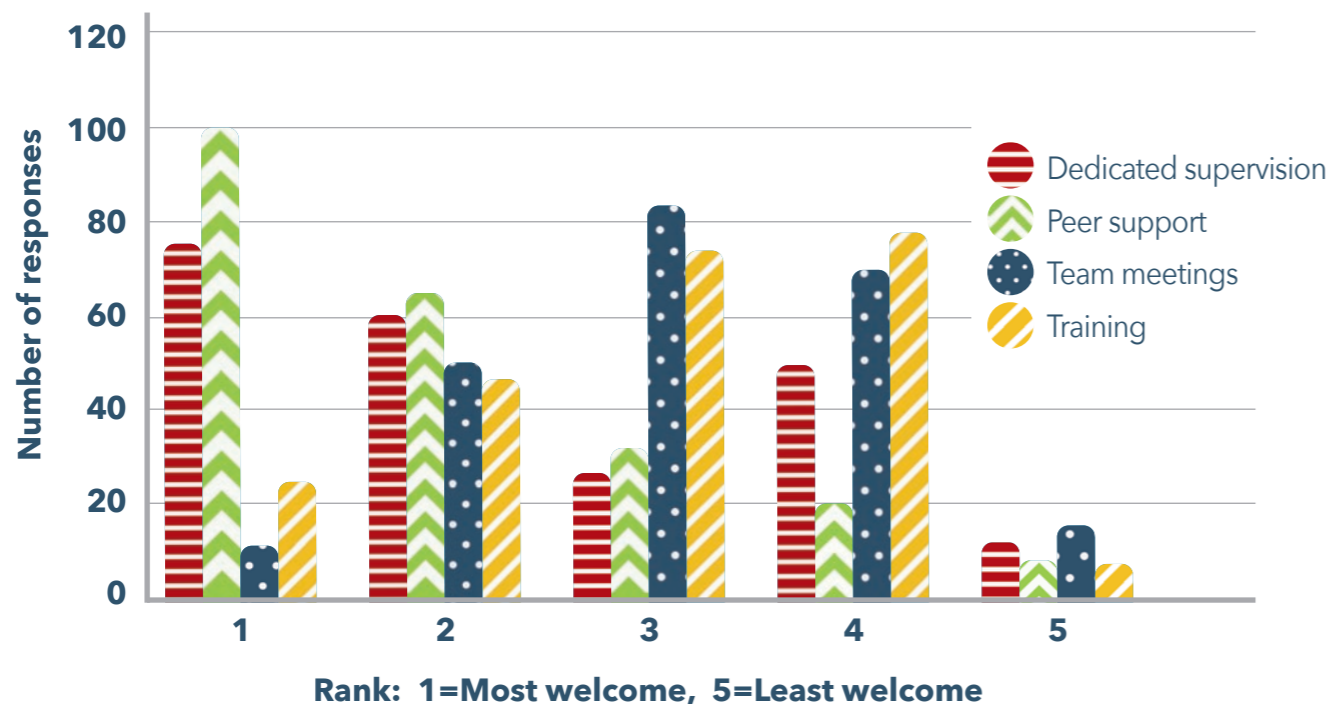
Consistent with the literature, the chart indicates that the majority find their AMHP peers and colleagues to be the most welcome and effective source of support. The next most welcome was dedicated supervision, which highlights the significance of the fact that one in four AMHPs do not receive any such dedicated supervision. Training and team meetings were seen as the least valuable strategies.

When looked at by profession, the marginal preference amongst nurse AMHPs was for dedicated supervision followed by peer support and team meetings equally whilst social work AMHPs had a significant preference for peer support ahead of dedicated supervision. Responses to the 'other' section included ad hoc supervision and reflective practice groups where these were available.

AMHPs and professional regulation

Who is your professional body?
(% total)

To further examine AMHPs' perceptions of the support they receive we asked them who their professional body is. We used a free text approach so that participants could apply their own understanding and interpretation around professional representation and regulation.

207 social workers responded to this question with 185 stating Social Work England as their professional body. The question was asked in the singular and so respondents provided only one response to this. Other responses included Health and Care Professions Council (HCPC), Social Work England/British Association of Social Workers (BASW), BASW, local authorities, local authority/Social Work England, AMHPA (a North West England AMHP forum), Care Council for Wales and there were 5 who were unsure or didn't know. As can be seen, respondents did not have consistent answers and this is one area in which AMHPs have a perceived role separate from that of their regulated profession.
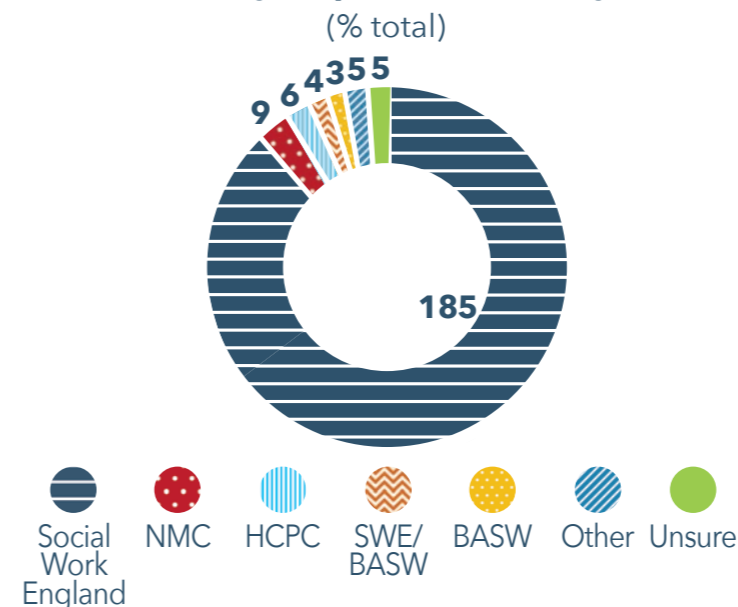
Of the nurse AMHP respondents 9 (90%) stated the Nursing and Midwifery Council (NMC) and the occupational therapist identified Health and Care Professions Council (HCPC).

We also asked AMHPs how their professional body understands or supports them with their role, inviting them to add detail or suggestions. On the whole, respondents strongly indicated that they thought their professional body did not understand and support their AMHP role, although some were pleased that this survey had been launched as a

means of developing an understanding. Some participants indicated that there was a need for AMHP regulation and saw the benefit of their regulator capturing their continuing professional development (CPD). It was seen as something that is positive and potentially an aid to further reflection.

Some suggested that their regulator could provide access to on-line resources, training, links and webinars. There were overlaps with BASW who were highlighted as a source for resources and there were suggestions that more links be established between Social Work England, BASW and the national AMHP Leads Network.

Apart from one nurse AMHP who said that the Nursing and Midwifery Council had been 'accessible and supportive', nurses appear to have experienced some shortcomings in the detailed understanding of AMHPs within their professional bodies:

"When I first approached the NMC [...] they did not know what an AMHP was"
(nurse AMHP)

"Currently it doesn't acknowledge my AMHP training and I can't add this qualification to my Nursing and Midwifery Council registration"
(nurse AMHP)

The occupational therapist had a similar view of the Health and Care Professions Council (HCPC).

Education and training

Finally, the survey asked AMHPs whether their qualifying training and education adequately prepared them for the AMHP role in terms of content and placement. The majority (75%) believed that it did, 14% thought not and 11% left this blank. In terms of the professions 183 (74%) of social workers answered yes and 36 (15%) answered no, 90% of nurses (9) answered yes and 10% (1) answered no and the occupational therapist answered yes.

Do you think current AMHP training and education prepares trainees adequately for the role (in terms of content and placement)?
(% responses)

11
14
75

Yes   No   Blank
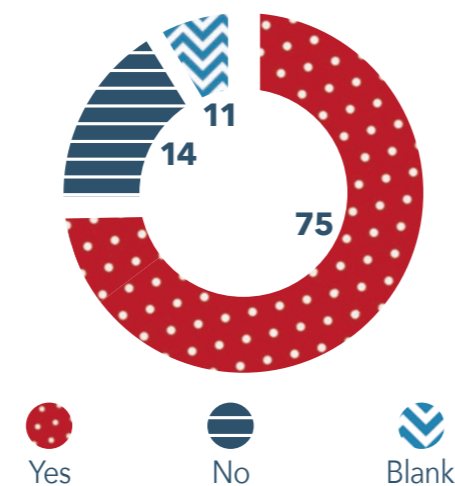
How education and training could be improved

The 14% who answered no were asked how training and education could be improved. Responses to this question were split two ways. Some respondents think that university-led courses are 'too academic' and that the accompanying portfolio is too onerous, should be assessed by the line manager and only ratified by the university as opposed to the current situation where universities mark and grade portfolios. Others thought the opposite: that the portfolio was 'too light' and that teaching should include more social work theories. The differences of opinion here are indicative of the variation in modes of delivery, level of partnership working and duration of the programme and placement, with no minimum standard and curriculum content across different university programmes. It may even reflect individual learning styles. Interestingly, some respondents thought trainees should be more experienced prior to undertaking the training and there were concerns that they may be forced to undertake the training too early in their career.

Suggestions for developments in teaching and training included:

- Greater emphasis on the emotional aspects of the role and managing the personal toll of ethical dilemmas. This included aspects of effective supervision

- Support to challenge the dominance of the medical model which does not acknowledge a psychosocial understanding of mental distress and the ways in which it informs AMHPs' choices and decisions around alternatives to coercion

- A meaningful implementation of social perspectives and how this translates in practice to least restrictive alternatives to hospital

- Advocacy training

- Assertiveness training, particularly in relation to challenging colleagues more robustly

- Joint training, for example with section 12 approved doctors

- Meaningful inclusion of people with lived experience to enable a clearer focus on the human aspects of the work, including trauma and distress

- More time spent on how the AMHP can involve the person in the assessment with perhaps some modelling as to what this might look like

Some suggested that supervision should be guaranteed for those who are newly qualified or, possibly, for trainees to continue to be observed post-qualification or to have access to a mentor.

Overall, there was a clear message that training and education should support critical reflection and thinking skills (as a means of developing their distinct professionalism) and not just teaching how to follow statute and codes of practice in a limited legalistic fashion. The need for time and space for learning and critical reflection was highlighted as part of respondents' opinions on the duration of AMHP training courses. Some suggested that the training was too short (e.g. where the training is three months) and there was a call for more dedicated time in mental health settings.

Where education and training works well

Where training is well received and deemed to prepare trainees adequately, which was the perception of the significant majority (75%), it is viewed as being at the right academic level. Tutors who are seen to be knowledgeable and supportive, particularly where they either have been or are still practising AMHPs, are well received.

Examples of good practice include:
- Practice focus of the course
- Placement including the opportunities to shadow AMHPs throughout
- Quality of academic lectures and legal professional input
- Protected study time
- Dedicated supervisors/practice educators

- Scenario based discussions
- Enabling the AMHP to advocate more robustly
- Close relationship between the university and the employer
- Tools such as training videos

AMHP refresher or CPD training

The majority of respondents were positive about the post-qualifying refresher training they received and indicated that it was effective. Some thought the 18-hour requirement had been 'watered down' to include topics not traditionally included in AMHP focused training and education. Some appreciated training that involved professionals from other key areas of the work.

There was, however, a parallel perception that post-qualifying training lacks variety and consists of little more than legal updates. Suggestions included opportunities to enhance supervision and to be able to access reflective sessions offering a safe space to explore the emotional aspects of the role. There were a number of observations that some negative consequences of the COVID-19 pandemic were that online training had limited opportunities to build relationships and offer mutual support.

We asked AMHPs who delivers their refresher training and they were able to select more than one provider. Nearly half

of refresher training is delivered by private companies followed by in-house training (29%) and universities (17%).

Who delivers your refresher training?
(357 responses)

In-house training | Universities | Private companies | Other

Dual specialisms: AMHPs who are also BIAs

We asked AMHPs whether they were also BIAs and 31% of our respondents said that they were. The only available national statistic is from 2018 which indicates that the average is 38% of AMHPs who are also trained as BIAs (ADASS, 2018).
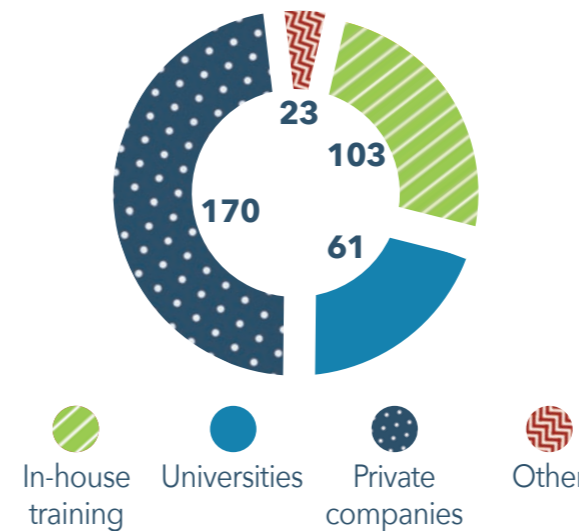
Are you also a BIA?
(% responses)

Yes | No | Blank
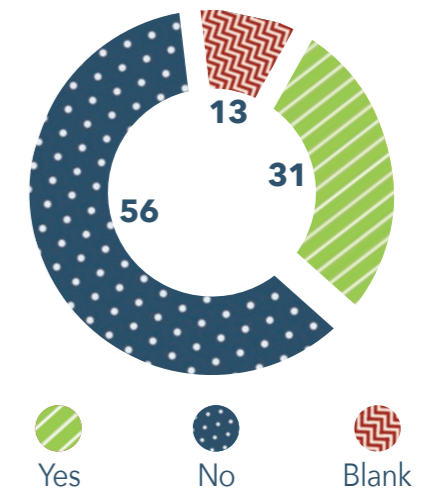
We asked those AMHPs who are also a BIA how the roles relate to each other. There was overwhelming positivity and recognition from participants that this dual specialism has benefits. Understanding the interface between the Mental Health Act and the Mental Capacity Act improves their understanding of options arising from a Mental Health Act assessment and provides a fuller legislative picture[4].

AMHP/BIAs gained a greater understanding of mental capacity in assessments and it enhanced their legal literacy and concentration on communication:

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[4] The recent review of the Mental Health Act (Department of Health and Social Care, 2018) found that it is not always clear to professionals whether the MHA or DoLS should be used if a person lacks the relevant capacity and does not appear to be objecting. Some believe that the Mental Health Act is too restrictive and constitutes a form of discrimination when DoLS might apply to the person. The White Paper has indicated that reforms will seek to clarify this 'grey' area by developing a clearer dividing line between the two Acts (Department of Health and Social Care, 2021)

"[It] informs the AMHP role and the boundaries of the Mental Health Act. The deeper knowledge of BIA has helped me to understand the complexity […] and the importance of taking time and care to try and engage and have a dialogue and narrative with the person being assessed" (social work AMHP)

A small number thought that AMHPs should also be BIAs as a matter of course. However, some stated that although dual trained they only practice as AMHPs, which may be explained by the way that services and teams are configured.

People with lived experience of Mental Health Act assessments and AMHPs

Fourteen people with lived experience of Mental Health Act assessments and detentions were interviewed. To analyse interview data, Thematic Analysis (Braun and Clarke, 2006) was used and a thematic coding framework developed to illustrate overarching themes, with sub-themes exploring these further. These are set out below with participants' experiences added for illustration.

Communication and the assessment
Elements and characteristics of good AMHP practice were identified. These included the importance of a caring and compassionate attitude, treating people as human beings and allowing those being assessed to tell their stories without imposing prescribed questions on them. This 'tuning in' was seen as having respect for the importance of peoples' stories:

"Just gauge the mood of the patient […] and know as much as you can. Let the patient relax and tell their story […] And I think it's important not to ask questions from a list […] that detracts from the human level"

"One thing I didn't like is that the AMHP sat there scribbling all the time rather than looking at [me] […] Whereas the next time it was totally different. It was a discussion […] They listened to me […] Eye contact [is very important] […] It's about the conversation […] It's what I call 'a joint venture'"

In agreement with the opinions expressed by AMHPs, people highlighted the importance of giving time. The importance of the relationship and having an understanding of the person was stressed:

"Having one-to-one time is really important […] if they're in your house [for a short time] then they've made their decision that's not good"

Researching and having adequate knowledge of the person's history and biography was seen by most of the people as being very important or essential:

"AMHPs need to be aware of the service user's life […] the AMHP needs to come to see the patient individually before the doctors. They don't do that, most of them anyway"

"It's just these random people waltzing into my house who I'd never met before and just introducing themselves and making a big decision about my life at that time. I didn't think that was particularly fair"

Being honest and transparent was important:

"[AMHPs should] give you some indication as to what sort of decision they might be coming to at the time rather than just impose it on you right at the end. Giving you some idea about what might happen and what they're thinking at that moment is important"

Going into an assessment with an open, non-judgemental mind when it comes to decision making was also important:

"I think there's sometimes they [AMHPs] know their decision before they even go in there […] and they already had the ambulance and the police waiting outside. So how can that be that they haven't [pre-judged] me?"

This correlates strongly with the clear themes articulated by AMHPs around information sharing, inclusion and the Empowerment and Involvement principle and an aspiration for shared decision-making. Many people said they had not been involved in decision-making:

"They always asked me lots of questions and stuff and then they always go off to have a conversation, so I'm rarely involved in the actual discussion"

"I can remember a few times where my parents have wanted to be involved in the discussion, but they've been told to wait outside or vice versa […] they've [the professionals] all gone into my garden"

"No options were explained [during the Mental Health Act assessment]"

There was an acknowledgement, however, that where people are particularly unwell or distressed this can be difficult. Being offered the option of voluntary hospitalisation or informal admission may not be in their best interests or lead to the right outcome:

"[Being sectioned] saved my life basically because I'm not in my right mind when I'm doing these sort of things […] so, thankfully, the last time they didn't even give me the option to go voluntarily […] looking back it was the right decision, even though I've hated being in hospital"

One person had suggestions for practice:

"If anything I would like changing it's to have a summary by the AMHP about why they made the decision they did […] I wish I had more written information to look back at […] I think we have a right to know why they made the decision they did"

Admission to hospital

Hospital was seen as being problematic for most and this affected perceptions of the assessment:

"[I felt anger] […] Because when I was last hospitalised I had an horrific experience […] that I found really traumatic last time […] and I was worried that they were going to send me back. I was furious. I was really, really angry. And really sort of scared"

This was linked to AMHPs' decision making, whereby:

"AMHPs don't see you once they've shipped you off into hospital and you're drugged up to the eyeballs. They don't come back. They don't see that side of you or that side of the care"

There was some ambivalence around this, however, as over two-thirds saw it (retrospectively) as being the right outcome, with one person describing hospital as being something they liked.

Power, stigma and ambush

Assessments have been experienced as intrusive or, worse, as an ambush, a threat, or a means of wielding power:

"It's been done kind of covertly […] It's always felt like the outcome is already predetermined […] All of a sudden they all kind of ambush me at the same time […] And the next thing I know is I'm being sectioned […] I don't think I've ever been involved in this"

The stigma of mental ill-health and psychiatry is also noted:

"If I'm a problem, they can section me. I always thought it was a threat. Your fault because you challenge them then they come back with a threat […] If you don't do what they want me to do then yo3u know we can section you […] We don't have power. We are mental patients"

Insights into discrimination, including organisational prejudices and poor practice, was observed:

"If you get a student or a newly qualified worker and they go into a unit to work with others, they adopt the stuff of the older one. They need to move forward and say this is how we do it now but they fall into that pattern […] they pick up on the sort of traditional ways. I suppose it's about calling out and recognising it when you see something that's not on and having the confidence to do that"

"There's a lot of prejudice […] towards people with borderline personality disorder. There's a lot of misunderstanding […] and sometimes quite a critical approach"

This was also linked to burnout:

"Prejudices [are from] a lot of the older experienced nurses and social workers [who] have been doing it for a lot of years who seem tired by the system […] and the reason is, it's a very stressful role"

AMHPs' workloads and time

People saw how AMHPs' workloads prevented time for meaningful, holistic and relational assessments:

"The AMHP forgot to mention the outcome of it when he left he was that rushed. He had to get to the next appointment. He failed to tell me what was happening. I had to ask the police officers what was going on"

"The AMHPs [are] there for five minutes to ask questions and gain the information from you […] They get the information and then go and make their decision elsewhere […] Or just not having the time […] because they are pushed and rushed and 'later but today I have loads of people to see'"

Resources to meet need

People spoke about the lack of resources, including the shortages of inpatient beds and the lack of choice:

"I always feel very out of control where I'm going [when sectioned]. I'm normally being sent to a PICU or something far away […] so I wish that I could stay closer to home"

"I think AMHPs struggle with the role because they don't have [any] alternatives to hospital […] Community services are so stretched with what they can do […] to be fair how are they ever gonna get this correct?"

"My aim [now] will be to go into a Soteria house and work through my psychosis there and like come out the other side, not medicated […] but obviously that's not available at the moment, so that makes it really hard"

Fostering hope for recovery was acknowledged as valuable and aspects of AMHP's power, ability to challenge and advocate were also noted - including the potential to use power for good:

"I don't know whether it's the thing about doctors because of status or something, they seem to have the power […] I think AMHPs need to rise up to the mark and become more powerful with the doctors […] I'm thinking there needs to be a bit of training for the AMHPs to go 'don't overrule me' kind of thing' […] Another good idea […] if you

could have two AMHPs to level out the two doctors!"

"Alternatives to hospitalisation [...] don't exist in a lot of places but [have] the ability to campaign for alternatives and stand up and be counted for the fact that not everyone needs hospitalisation."

"One thing [the AMHP] did that was good [...] the psychiatrist wanted to put me on Clozaril [...] [and] he was trying to force his perspective on me [...] And she did say it sounds like you've got capacity to refuse Clozaril because I wasn't refusing medication full-stop [...] And she backed me up on that"

The impact of trauma

The need to be trauma-informed came through relatively strongly, with 5 people stressing the importance of this:

"Not everyone, but a good proportion of people, have got some history of some kind of childhood abuse [...] Across the board, from police to ambulance men to nurses, and A&E, to psychiatric nurses [...] [there needs to be] training about the effects of trauma"

Some people described detention – or the prospect of detention – in terms of trauma:

"I remember [...] being terrified [...] I think it was a complete sense of loss of control [...] something was happening to me and it was very scary"

"I remember feeling quite intimidated in a room full of people I've never seen before, and some of them were ready to sort of [...] in case anything kicked off sort of thing. So yeah, I kind of dreaded seeing those people if I saw them in any other setting 'cause it was so [...] traumatic"

Professional identities

This project was co-produced with people with lived experience of assessments of Mental Health Act assessments. In most cases the people we interviewed were not aware of the professional background that the AMHP came from, which is likely due to the fact that the AMHP will be introducing themselves as an AMHP only without sharing their professional background. Only 3 people knew about the AMHP's professional background and this knowledge appeared to have been gleaned retrospectively, or coincidentally, rather than it being routinely shared. During the interviews some people did share views about the professions, albeit not from their experience of Mental Health Act assessments but rather from their knowledge and experiences of mental health professionals more generally.

People considered the ways in which workers from different professional backgrounds would hypothetically bring different skills to AMHP work:

"I think I would have loved to have been assessed by an occupational therapist AMHP 'cause I've met some fantastic occupational therapists in the past. [What has been good about OTs?] I think they're [...] non-judgemental, so to speak"

A number of the people interviewed indicated they prefer AMHPs to be social workers:

"The different AMHPs I have had have tended to be social workers [...] social workers tend to know more about what's available in the community"

"Social workers engage at the human level and not the conditions [...] I think that's massively important [...] and I'm not overly convinced about psychologists being AMHPs, you know [...] For me they are like psychiatrists and [...] you've got to be very careful"

"Nurses go into specialist fields and then go onto nursing management. Nurses would be engaged with patients in a very different way to [...] social workers"

As highlighted elsewhere in this report it appears that there is a conflation of perceptions of nursing with their medical and clinical organisational settings as well as with doctors. Note that the participants here were not describing nurse AMHPs

(this is not information they had) but their experiences of mental health services more broadly (and historically):

"Social workers seem to have a more social background and looking at us [...] you know [...] for the person [...] The medical thing is what I'm against. 'Cause you've already got two doctors in there, you need one with a different perspective. If you put a nurse in there, which they can do, or a psychologist or an occupational therapist, they are kind of adding to the medical model"

"It's about how they react. Social workers tend to be more laid back and chilled out, dress like normal people [...] Occupational therapists are even more [...] normal! Nurses are like medics [...] If I'm off it the social worker will say 'what's happened'? The medical profession will say 'pop a couple of extra smarties"

However one person was not encouraged by non-clinical assessors:

"I'd be thinking of the hierarchy – you're just a social worker. The doctor is higher level so how can you section me? I wouldn't have accepted it if an occupational therapist tried to section me. 'Cause of the little knowledge I had of mental health services and the way they work and the techniques and the way they go about it. I'd have wanted the psychiatrist – I thought they were the head doctors"

Overall, the professional background and identity of AMHPs does not seem to make a difference and people in acute distress may not be interested in this:

"I would have to say no [there isn't any difference] because I mean they all do the same course don't they [...] And they must be trained in the same approaches, assessing patients"

"I wasn't bothered by it [...] it didn't bother me because things were so desperate. I didn't care who it was as long as [...] If it's somebody who's got a lot of learned understanding about the complexities of mental health and how all that works then it doesn't really matter"

Some insights were particularly revealing. Adding to AMHPs' own concerns about their invisibility, for people with lived experience it was highly likely to be the case that they did not know what an AMHP was, the fact that they had an independent role or that there was one present:

"I didn't know [until now] that they were independent [...] I don't really have much knowledge of what they're there for other than [...] a third pair of eyes almost"

'[AMHPs] [...] just kind of stay quiet and have the doctors to do most of the talking ... whenever I've been sectioned the AMHP's involvement has always been [...] just part of going through the motions really"

"I guess with the AMHPs [...] they kind of fall into the shadows a lot. I think that they're like background people for me. It's much easier to remember the consultants that were there [...] I think

it's because they seem to play second fiddle to the psychiatrist [...] The AMHPs blended in the background"

Yet this perceived powerlessness of the AMHP stands in stark contrast to the notion of the AMHP as a more powerful figure:

"I used to regard [the AMHP] as the Grim Reaper! [...] It just makes sense because after all your liberty [...] you get that taken away and the human rights"

Training and education

People were asked for their views or suggestions for AMHPs' training and education and were invited to comment on what they saw as being essential knowledge:

"I suppose [...] education about what it actually feels like to be an inpatient [...] You can go on inpatient units today and still see the way that bullying happens. And you know the stuff around the power. That and how we take people's power away from them"

Having people with lived experience contribute to AMHPs' training was seen as essential by several people:

"I will go there and say you can ask me whatever you like and I will answer you ... Get them to talk to people it's happened to [...] get their point of view. I asked them what they want to know [...] I don't mind what they ask me, but I [...] can help communicate and help them do it a different way. Sometimes it's how you ask a question, isn't it?"

Nearest Relatives' experiences of Mental Health Act assessments and AMHPs

We interviewed two people who had experience of the Nearest Relative role in Mental Health Act assessments. In keeping with the message from AMHPs and people with lived experience there is a recognition that AMHPs are very busy and don't always have time to do things in the way they would like to. Both recognised AMHPs' aspirations to communicate effectively, offer time and be supportive, but also that they are 'often doing impossible tasks on their own with no support'. Both people were aware of the AMHP role to a greater or lesser degree: both were aware of the legal functions around consultation, but not necessarily that AMHPs were the applicants and decision-makers. Both knew that the AMHP had to be there with a doctor in order for a person to be detained in hospital and that they were part of the assessing team but neither were sure what the job actually involves. There was general speculation that the AMHP would need to agree with the doctor's statement.

The fact that AMHPs have very few alternatives to hospital admission was picked up and there was some regret that there were no less restrictive alternatives to hospital such as adequate and effective crisis services or houses, including Soteria houses.

Both Nearest Relatives had a different experience of their relative's hospital admission: for one, it was seen as being a 'huge relief', helpful and conducive to recovery; for the other, hospital wards

were powerfully described as 'the land that time and conscience forgot' and which are not always therapeutic or even safe in the way they can re-traumatise people who are experiencing extreme states of mental distress. Again, in keeping with our interviews with people with lived experience of assessment and detention, there was a recommendation that AMHPs spend time in hospital wards to further appreciate the implications of their decision to detain.

Recommendations for training, knowledge or skills development incorporated aspects of communication, for example Open Dialogue techniques, to further work with the different dynamics and differences of opinion that can be part of a Mental Health Act assessment. One person spoke about a 'hierarchy of involvement', expressing their observation that inclusion and decision-making operates from a 'top down' perspective. In general terms, both perceived that they had been involved with the decision-making although one believed that there was a tendency to treat the relative as a problem (particularly if they disagree) and that the experience of Mental Health Act assessments and detentions can be dehumanising for Nearest Relatives and for the individual person.

Both people understandably described the circumstances as having moments that were dramatic, stressful, difficult and exceptionally worrying. Some regret was expressed that Mental Health Act

assessments are 'one-off' activities which limits communication and the opportunity for debrief. The level of worry and helplessness, when recognising your relative's distress, can be exhausting and not something you can prepare for with an instruction booklet. One person thought that relatives' psychological difficulties and uncertainties are not very well documented or accounted for. There was a recognition that AMHPs are busy and concerned with the process and legality of the situation but that they don't always check in with the 'difficult side of things' and leave room for talking. Both found other means of support such as self-help groups or networks. The message for AMHPs and mental health professionals generally is that it would be helpful to find time to talk, including after the assessment, and perhaps to consider a form of debrief. Interestingly, one person pointed to the training that

medical staff receive around communication and breaking bad news and that effective communication techniques should perhaps be something that are taught on AMHP programmes.

From their experiences, the AMHPs had always been social workers, although one was not clear whether they were attending in the role of a social worker or as an AMHP. When asked if it would make a difference if the AMHP was a social worker, nurse, psychologist or occupational therapist, one person thought that as they all presumably have the same sort of training they would probably trust anybody from any discipline that had the qualification. The other believed that social workers were better placed to undertake the work as they saw things from a non-medical perspective, could take a more critical approach and could advocate for more appropriate crisis housing.

Approved Mental Health Professionals: Focus Group themes

At the end of the survey, AMHPs were invited to take part in online focus groups to further explore some of these emerging themes. There was an interesting pattern in terms of representation[5]. With all four focus groups combined, there were 19 social workers (90%) and 2 nurses (10%) which is a higher proportion of nurses when compared with the national representation of 4% (Skills for Care, 2021). There were 10 females (48%) and 11 males (52%) which, given the national weighting of 73% female and 27% male, gives an overall picture of almost double the representation for men[6]. In terms of ethnicity, 16 (76%) described themselves as White, 1 Black (5%), 1 Euro/British Asian (5%) and 3 (14%) were not disclosed. Of those that disclosed their ethnicity, this is an over-representation of White AMHPs.

Motivation

We were interested in exploring the reasons AMHPs went into the work so that we could understand key motivating factors and examine whether this was different across the professions. For many, it was explained as a contractual

obligation whilst a small number indicated that they were required to undertake the training due to a shortage of AMHPs on their rota, a longstanding issue. This also raised questions around suitability and links to retention problems.

A common theme was the way in which AMHPs were inspired by colleagues:

"When I was a young social worker [...] you looked around [and] saw these ASWs and they were what you wanted to be" (social work AMHP)

A small number enjoyed academia and education and were in pursuit of further training. An ever-present theme throughout the AMHP focus groups was the way in which AMHP training is, for social workers, seen as being a 'natural progression', part of 'career enhancement' and, in many respects, the only opportunity for social workers to be able to progress their careers without becoming managers:

"I don't feel the need to get up the greasy pole, that doesn't interest me at all. Organisations [...] need experts and we are all experts in [mental health law]" (social work AMHP)

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[5] Demographic details for individual focus groups can be found in the Annex

[6] Previous explanations for an over-representation of men in this field of work have focused on pay, power and masculine notions around risk (Rolph et al, (2003))

AMHP work as advanced social work

As with the survey findings, most of the social workers who took part in the focus groups made reference to the ways in which AMHP work was advanced or 'proper' social work and that it was an opportunity to promote a social perspective in mental health settings. It also added weight to their perceived advocacy role. Some had observed poor or unlawful practice and, motivated by their professional social justice agenda, they saw the AMHP role as key in building on their legal knowledge and having additional powers and authority to be able to address this:

"Work kind of was under, unfortunately, psychiatrists in the power dynamic and I really like the idea that this was a role that would offset the medical model and champion the social perspective" (social work AMHP)

Many appreciated the ways in which their AMHP role keeps their knowledge up-to-date, speaking of 'sharper' skills and practice, confidence, 'practice wisdom' and the ways in which the AMHP Practice Educator role keeps you 'on your toes'. The combination of power, authority and expertise meant that they were practising:

"[…] advanced social work and the three pillars of social justice, human rights, and professional integrity all in one; forcing others to look at the bigger context: the poverty, the inequality, the trauma and not just that individual person […] it's cutting edge social work" (social work AMHP)

Nurse AMHPs all related to the idea that it was advanced practice with one adding 'it just seemed absolutely essential knowledge and I couldn't believe I didn't know it'. There were clear overlaps in terms of the knowledge and role requirements but nurses did not specifically locate it within an 'advanced social work' model. AMHPs also recognised their need to be assertive in the role, with this relating to their having a 'firm-footing', being 'sure-footed' and 'steadfast' in their role in a multi-disciplinary scenario where a lot was at stake.

AMHP work as rights-based, justice focused and advocacy

AMHPs were asked what they value about the work and there were clear and ongoing references to aspects of justice and an ever-present focus on people's rights. The striving for fairness came through very clearly and strongly:

"I have got this burning desire for things to be fair" (social work AMHP)

"You're with this person against the system" (social work AMHP)

This absolute commitment to justice and fairness led to AMHPs 'holding systems to account' and challenging language and attitudes that they saw as being oppressive or discriminatory (or at times unlawful), being assertive and having people with whom they work 'have a voice'.

AMHP work, power and challenge

Associated with the striving for equity, a strongly recurring theme throughout all focus groups was the use of professional and statutory power as a means to level perceived professional hierarchies and to challenge poor or oppressive practice. This was about relationships with medical colleagues at an interpersonal level but it was also clearly and consistently about relationships between healthcare trusts and local authorities at an organisational level. The frequent references to 'power dynamics' were interwoven with the perceived high status where AMHPs are seen as having expertise and specialist knowledge which they use to level the playing field. They have the 'clout to properly hold people to account' as they strive for equity within organisations that were seen as hierarchical. Further, one social work AMHP summarised the ways in which they may even 'say something provocative to get people to reappraise and rethink what they are doing' for the greater good – this power was consistently expressed as being exercised on behalf of the person.

AMHPs' statutory and professional independence was strongly factored into this: they did not perceive that they were 'bound by hierarchies' and their independence from organisations was referred to as a 'no mans' land' (which was not conveyed as being problematic). For a small number, this extended to a motivation to work out of hours, as its associated freedoms were attractive.

AMHP work as varied work

AMHPs enjoy the variety and spontaneity of the work and the fact that every day is different. This was seen as a break from the more boring aspects of computer or desk-based work and was illustrated by reference to the 'twists, turns and evolution of assessments' that were 'never dull'. Some enjoyed the fact that it is a more discrete role, compared with long-term casework, as it consisted of 'one-off' pieces of work.

Resources to meet people's needs

Inevitably the lack of resources was an ever-present theme and there was a constant striving for alternatives to admission and a sense of failure and 'guilt' around being unable to achieve this. The AMHP role offers a clarity of decision making within a framework of legal obligations and duties but this is clearly constrained by a fundamental inability to meet people's needs due to a lack of resources. People being sent to out-of-area beds is a problem in some areas leading to lengthy travel and time-consuming problems in terms of trying to ascertain whose responsibility it is to undertake associated work. Where there are no beds, people are being assessed 'over and over and over again' and these repeat assessments are time-consuming but, more fundamentally, they represent a failure to meet someone's needs where they are left waiting in inadequate, unsuitable and sometimes unsafe environments. This was the prevailing view that was a priority concern in all focus groups for all areas nationally.

Pressures of time and workload

Having no time to do the work, feeling rushed and the fact that 'everyone is swamped' was a frequently expressed concern and source of stress. This was in relation to the volume of work and number of referrals to process but it also related to pressure from others. AMHPs felt rushed and pressured even where there were serious implications such as seeking a warrant to enter people's homes with the police. They wanted to be able to say no, advise on alternatives and ultimately to 'slow things down'. AMHPs believed that their role is to act as a brake and prevent oppressive outcomes but they very often felt under pressure around their decision-making. One AMHP expressed regret that at times the work seemed to be 'an exercise in who can do it the quickest' and others spoke of the ways in which their assessment requests 'go from one to another to another'. This was a shared theme that led to many AMHPs describing how it limits family involvement and reduces opportunities for debrief or discussions with colleagues who need them to 'just get on with it'. Significantly, there is no time for report-writing, where catching up on reports can take days or are completed in the AMHP's own time.

Empowerment, involvement and working with people

Many AMHPs expressed great concern and deep regret that the fast pace of the work - potentially including the assessment itself - meant that they were not able to spend time with the person, support shared decision-making and embed the Empowerment and Involvement guiding principle. Being rushed into decision-making was at the expense of a good outcome for the person. Several AMHPs echoed the statement that they 'shouldn't be a conveyor belt' and are 'working with people, not files and bits of paper'. The tension between the idea of advanced work and the inability to complete this thoroughly was a clear source of stress. AMHPs said they would welcome more time to speak to people and their relatives and generally 'do a bit more signposting but then a new assessment comes so there isn't time for that'.

The personal toll of AMHP work

Linked to workload concerns were the sheer demands of the work and the personal toll it takes. AMHPs spoke of being out throughout the night (including where this followed on from a day shift) with no-one to relieve them and

"even things like getting food and going to the toilet – I can't think of any occupations where you can't take a break because there's no cover. We are an anomaly" (social work AMHP)

One social work AMHP suggested that we should 'apply Maslow's hierarchy of needs to ourselves' as they can not get the profound self-awareness and relational work right if they don't have their basic workplace needs met.

Lone working concerns were expressed, along with a sense of abandonment, whereby

"Nobody addresses the fact that two doctors can sign a recommendation to say that a person is so mentally unwell that they need to be in hospital yet we're going to leave them in the sole custody of this AMHP for five hours while they wait for an ambulance or a bed" (social work AMHP)

Service and team structures

There were questions raised as to the impacts of full-time AMHP roles or roles where AMHP work is split with other duties. The restructuring of AMHP services needs a greater understanding as to its impact: there were conflicts around whether full-time or split roles were more or less stressful.

Professional differences or organisational differences

There was no clear way for us to discern whether AMHPs' regulated professional roles made a difference to practice as all AMHPs generally had shared experiences of the work and they coalesced around their shared AMHP professional identity and experiences. We did hear some mixed views and it is possible that our focus groups had different types of discussion depending on whether they were social work AMHPs only or were made up of a mix of professions.

Organisational and multidisciplinary factors did, however, frequently come to the fore and this seemed to distil into a perception that healthcare trusts have power and influence at both a micro and macro level. The ways in which 'health systems' hold the resources is 'stacked against AMHPs' who are not enabled to do their jobs but yet are simultaneously held to account.

In relation to professional identities, there were mixed views around AMHPs being from a social work or nursing background. When this was explored in-depth some saw differences whilst others believed that nurses undergo a form of transitioning:

"When nurses become AMHPs they see things in a slightly different way" (social work AMHP)

There were worries about what the organisations (and thereby employees of these organisations) represent:

"We were concerned that perhaps nurses were […] because of the hierarchy of the NHS […] more likely perhaps to rubber stamp, and that was a real concern of ours. But my experience of nurses here […] it's not that" (social work AMHP)

Nurses also picked up on this stating:

"There is a kind of a narrative and concern that nurses are trained to say yes to doctors. I've been told that face-to-face and that's people's understanding of what nurse training is, and it really, really is about 50 years out of date."

"The power dynamics have been challenged and challenged and challenged for the last 20 plus years. Nurses really, really are spending an awful lot of time and effort and training in developing nurses who can challenge doctors. There needs to be a shift in thinking that nurses are trained to say yes to doctors, it's not how it is."

There were mixed views but also a general coalescing around similarities:

"I don't think that social workers don't want nurses to be AMHPs - I've worked with nurse AMHPs who are very inclusive" (social work AMHP)

"Nurses bring a wonderful skill set which is different to mine but complementary" (social work AMHP

"I think there's a lot of misunderstanding around nurse training. I'm still used to hearing, you know, it's all medical model blah blah blah when it isn't." (nurse AMHP)

"We probably do make too much of the differences and not enough of the similarities" (nurse AMHP)

AMHP identities and 'cross-fertilisation'

A particularly interesting and valuable observation was the way in which a social work AMHP described developing their complementary clinical knowledge 'through osmosis' whereby:

"You work with your colleagues [...] and you have this inter-cross-fertilisation of knowledge and skills and that's what you get for having 20 years and a bit with working with other colleagues in a MH team" (social work AMHP)

The 'merging' aspect of the work was also highlighted around nurse training, where nurse AMHPs added:

"There's more opportunities for nurse training to get a more community [rather than ward] based training and work alongside other disciplines […] I think that would have an influence on it"

However, it was also pointed out by a nurse AMHP that:

"I think social workers have a kind of a […] 'We have a separate mentality' that nurses could learn a little bit from. But I do also see the benefit of just thinking we're all in this together"

There were several observations that the problems were organisational and structural and not professional. Again, there was a conflation of a nursing approach with the problems of an inherently hierarchical organisation which nurses were seen to automatically represent:

"When I talk about nurses I'm not saying nurse AMHPs, 'cause I don't have any experience of that, but the setup in Community Mental Health Teams and the hierarchy in the system that AMHPs work in […] they're often [put] into that position of being subordinate, in a chain of command, and I think that's really difficult for nurses to challenge" (social work AMHP)

Importantly, however, there was recognition that social workers are not necessarily always consistent in their approaches:

"I've worked with lots of nurses […] and if they didn't say that they were a nurse, you wouldn't know. And I've met some social workers [and] depending where you did your training and how you present yourself and what sort of team that you're in […] you wouldn't necessarily align them with being social workers unless they told you. We need to be very careful about the pigeon-holing that we do" (social work AMHP)

"Our AMHPs are social workers but when we screen referrals […] it's not unusual for one to come to a completely different decision to another […] their decisions differ quite widely so it can't all be about primary profession" (social work AMHP)

Findings here mirrored those within the survey data. Overall, in terms of organisational structures, there were mixed opinions and experiences. One social work AMHP believed strongly that by residing within the local authority the AMHP retains a power and a 'rebalancing' but, simultaneously, another social work AMHP regretted the separation of health and local authorities in their area, seeing it as a 'loss of skills' from both sides.

Shared training and shared workplaces

There was a recognition that whilst the AMHP role might align more closely with social work than the other professions, this was not to the total exclusion of the others. Shared training, followed by the quotidian, everyday flow of AMHP work and its peer support brings about a shared way of working.

Overall, there was a fairly settled picture of AMHP work being about an individual approach and attitude that was less informed by professional background and more about personal values and an ability to challenge.

Structural barriers for non-social work AMHPs

Our findings were consistent with research to date. Many AMHPs spoke of organisational and structural barriers for non-social workers:

"It's a shame when we're trying to have negotiations to get other disciplines into being AMHPs 'cause I think it enriches the team [...] But there's a resistance, whether it's from the trust or whether it's from other professionals […] Will the NHS or your team agree to you being on the rota as frequently as is required? There's also the issue of financial remuneration"
(social work AMHP)

The conversations about professional identities often moved into structural problems around accessing training. Two nurse AMHPs' experiences were that:

"Unfortunately it wasn't that easy to get on the course 'cause there was, and I think there still is, a lot of resistance to nurses coming into AMHPing. If not from AMHPs but from organizational level. I think it's more of a structural thing, I think there's resistance from the trust and probably from the Council in protecting jobs for social workers."

Other AMHPs from social work and nursing backgrounds identified that the separation and de-integration of health and social care departments has been problematic in this regard.

Rewarding AMHP work

Many positives to the work were identified. All AMHPs referred to the fact that there is no better feeling than working with the person, having time to talk and make a joint decision not to detain or, alternatively, seeing someone who is unwell get access to appropriate care, treatment and support. AMHPs generally acknowledged and respected the fact that they see the most 'exposed' part of a person's life and that to go and assess somebody when they are at their most vulnerable and distressed is not to be taken lightly. This recognition and aspiration to return choice and dignity to a person at this time in their life led to feelings of their own empowerment when the person could be supported to take control over their destiny.

Given these challenges, AMHPs recognised that it shows the skills they have and how good they are at their jobs:

"We cope and we manage. I think we're doing the best for the person where the doctors come and go really quickly to get to the next one to get the money. It says a lot for us of how good we are and how we think on our feet and do what we can"
(social work AMHP)

Emotional aspects of the work

Consistent with some of the earlier literature, many AMHPs made reference to the adrenaline, excitement, 'buzz' of the job and 'rollercoaster' within the overall context of the intensity and complexity of the role. Some related this to their own need for stimulation and, again, it was part of the general aspiration to challenge and progress the social justice aspect to the work.

There were, however, parallel and consistent references to the absent or inadequate resources and the consequences of this lack for the AMHP. Time and again they stressed their professional obligation to pursue less restrictive community alternatives where this could prevent a hospital admission. Being thwarted because of a lack of resources led to feelings of failure to complete the work as it should be completed:

"I'm increasingly backed into corners about making resource-based decisions over clinical decisions"
(social work AMHP)

"You don't want to detain. But what is the option? And that for me is the biggest problem […] whatever community facilities are out there are inadequate"
(social work AMHP)

"I think the hospitals in [local area] are particularly unpleasant places to be. I wouldn't want a family member of mine being in one of them and I always feel quite compromised when making decisions"
(social work AMHP)

Consequently these stark and profound emotional aspects impact on the AMHPs with clear and unavoidable links to stress and burnout. This was heavily present throughout each focus group. AMHPs spoke of the ways in which they seek social justice but are now oppressing people. One referred to a 'moral injury to myself and sense of guilt about the role I am pushed into pursuing'. This was linked to a lack of understanding of the 'morally dubious situations' they are placed in. Through a sheer absence of alternatives, AMHPs are using warrants, detention, statute and broader aspects of coercion far too frequently. Some linked this to outcomes for people from Black and Minority Ethnic/non-white backgrounds and that it is hard to enact justice under these circumstances, no matter how hard they tried not to be 'part of the problem'. Similarly, and linked to the situation on mental health units, one social work AMHP spoke of the dangers of becoming

"numbed out to the fact you're putting somebody onto an un-therapeutic ward when we're telling people you need some time to recover and you're saying so many half-truths"

AMHPs frequently articulated the emotional impact on themselves. They spoke about the ways in which it is a 'raw role' both for themselves and the people they assess and about the ways in which they invest their own self (going 'deeper into our own journey and who we are') as part of the work. They spoke of the work being 'traumatic' and that they have been in tears, particularly where they identify with the person's experience. AMHPs spoke about 'engaging with our own feelings' and the 'extreme connections with our own feelings'.

There was an acknowledgement that, paradoxically, this makes you a better AMHP but:

"the way I work is at a cost – exhaustion – people who make the best AMHPs have the highest toll on them – nothing in the system which protects them"
(social work AMHP)

"the emotional battering that we get […] Whether that's our own empathic nature, perhaps, but emotionally, I think it has a major toll"
(social work AMHP)

Burnout was identified where 'some have no feelings behind their eyes' but there was a recognition that this could happen to anyone due to the trauma involved in the work. These thoughts and feelings – shared frequently and independently – were linked to supervision where there appeared to be a range of experiences. One AMHP observed that they often don't acknowledge or discuss this within supervision:

"[AMHPs] will describe the law and process but avoid their own psyche that brought us into the work"
(social work AMHP/AMHP manager)

Some areas have stable AMHP teams whilst some areas have ongoing vacancies. AMHPs worried, however, that with the rates of dropout and retirement as they currently are the situation may become even worse.

Being invisible or misunderstood

There is a general perception that the AMHP role is misunderstood and under-valued:

"We are asked to be superhuman – aware of biases, power, wanting to do the right thing, to 'show up' properly and this gets lost […] how bloody hard the job is"
(social work AMHP)

Several references were made to the fact that the role is 'invisible' or 'misunderstood' and that 'people don't have an understanding of where you're coming from', both within the services (i.e. non-AMHP colleagues) and also more broadly in terms of public knowledge or media references, where portrayal of Mental Health Act assessments are inaccurate, overly medicalised, or where the AMHP is totally absent:

"[We need to] change the public's view of mental health […] and how hard [AMHPs] work […] and it doesn't help when people have unrealistic views from soap operas that you can get hospital beds and specialised units no problem […] not at the end of the country and you've got to wait four weeks before you can get a place"
(social work AMHP)

In terms of organisations, the lack of understanding of the role and its demands and broader professional remit is misunderstood:

"You just can't click your fingers and we're out there in two seconds, they just don't seem to get it"
(social work AMHP)

and this adds to the demands:

"All the things that are unwritten are the things that get left to the AMHP. Everything is automatically assumed to be the AMHP's job"
(social work AMHP)

Similarly, AMHP services were referred to as 'dumping grounds'. In a practical and tangible way it included the inability to engage others:

"We can't get the police to come out and assist us, even with a warrant […] no-one will commit to when it is going to happen"
(social work AMHP)

AMHPs stressed that the assessment is the 'easiest part' of the process:

"It's all the rest of the stuff that goes with it that is difficult and stressful. By the time you actually get to the assessment, you are up to here anyway with all the hassle that you've had in trying to coordinate it"
(social work AMHP)

Support

Across all focus groups, AMHPs' support was clearly found from AMHP colleagues. There was a sense of collaboration and comradeship throughout. It was clear that many AMHPs had been badly affected by the COVID-19 lockdown: they spoke of isolation and stress to the point where they had 'buckled under' and had to take time off. This peer support, sharing of knowledge and shared reflection sustains many AMHPs. Teams and colleagues were described in a way that was indicative of a form of supervision. Frustration, stress and burnout is clearly exacerbated when there is no space to reflect and no colleagues to do this with.

In keeping with work pressures, assessments being 'queued up' and the suggestion by a nurse AMHP referred to above that it was 'an exercise in who can do it the quickest', there was one particularly interesting observation which contrasted with perceptions of peer support so strongly regarded elsewhere. Here, as well as being 'comrades' and an essential source of support, AMHPs are their 'own worst enemies' and they compromise each other's independence:

"You get into work and find an assessment [already] booked […] All the way along with training we're told this is our assessment, we control it, that's what our role is. And yet we do it to each other. An assessment has already been arranged when we know damn well [we] haven't had time to speak to the relative. We do it to each other all the time. So I think we're the best people to have around. And also the worst to have around because […] We don't do ourselves justice […] I [want to] set my assessments up [and] choose who I will take with me. I don't want you to have two doctors lined up" (social work AMHP)

Some AMHPs spoke about having a love/hate relationship with the role and, whilst many talked about how much they enjoyed it, they recognised that due to the propensity for burnout it was a time-limited role. A clear and resounding message from many AMHPs is encapsulated as:

"[It is] not a job that you can do alone for any sustained time, and I think it is also about burnout after all these years of this relentless […] chivvying and challenging" (social work AMHP)

Workstream 2: Best Interests Assessors (BIA)

Overview of the role

The Best Interests Assessor (BIA) is a newer role than that of the AMHP. The Deprivation of Liberty Safeguards were introduced into the Mental Capacity Act 2005 by the Mental Health Act 2007.

BIAs are charged with carrying out assessments under the DoLS framework on behalf of local authorities to ascertain whether a person in a care home or hospital is being deprived of their liberty and whether that person has the mental capacity to consent to the arrangements being made for their care or treatment.

In some ways the role parallels with that of the AMHP which is unsurprising given the DoLS framework was created to fill a gap in the law left by the Mental Health Act 1983. Both carry out assessments of an individual in order to determine whether the person meets the criteria to be deprived of their liberty in order to receive necessary care and treatment in relation to a mental disorder, albeit the DoLS does not authorise treatment. In UK law every person has the right to liberty under Article 5 of the Human Rights Act 1998, although this is a qualified right which can be overridden in a necessary and proportionate manner for which there is a procedure in law to regulate this process. The BIA role is, firstly, to make a judgment as to whether the person is currently being deprived of their liberty and then, secondly, to make a

recommendation about whether this should be legally authorised to continue for up to 12 months. Both the AMHP and BIA roles involve working with a medical doctor to make the final decision and to be able to perform either role requires an initial training programme via an approved Higher Education institution.

There are other differences in the scope of the roles with the AMHP carrying out assessments in the community to decide if an individual needs to be conveyed, possibly against their will, to a psychiatric hospital for assessment and/or treatment under the Mental Health Act 1983 (amended 2007). BIAs often make decisions about individuals who are already being deprived of their liberty in care homes or hospitals and who may have been in this situation unlawfully for some time.

The key statutory instruments for the Best Interests Assessor role are the Mental Capacity Act 2005 and the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008. These set out that a BIA must be either a:

- registered social worker
- level one registered nurse
- registered Occupational Therapist
- practicing psychologist registered with the British Psychological Society's Register of Chartered Psychologists

It also suggests that a BIA may be an AMHP. Local authorities are responsible for employing a sufficient number of BIAs and they must ensure that anyone acting as such has at least two years' post-qualification experience and that they have completed a training course for the role from an institution approved by the General Social Care Council (subsequently taken on by the HCPC and now by Social Work England). The Best Interests Assessor role will no longer exist when the Deprivation of Liberty Safeguards are replaced by the Liberty Protection Safeguards (LPS). The legislation for this, within the Government's current plan, is for implementation in April 2022.

The Best Interests Assessor role will then be replaced by the Approved Mental Capacity Professional (AMCP) and there will be differences in the role, although the full extent of the differences will not be known until the Code of Practice has been published in 2021. The plans suggest that the AMCP role will be quite different from that of a BIA as they will not formally assess every person who is put forward for LPS. Instead, they will assess only those people who are objecting to their care or treatment, those people who are living in an independent hospital and those cases considered by a local authority (or NHS Trust) to require more in-depth assessment. They will also make determinations, rather than recommendations to supervisory bodies, about deprivations of liberty. The final detail of the role will not be known until the Department for Health & Social Care publishes the relevant statutory instruments and a new Code of Practice later in 2021.

The Principles

The Mental Capacity Act 2005 has five overarching principles which Best Interests Assessors (and all acting under the Act) must adhere to. These are paraphrased below:

1   Start with the presumption that people have the capacity to make their own decisions

2   All practicable steps must be taken to support people to make their own decisions

3   People must not be treated as unable to make a decision just because they make an unwise decision

4   Any decisions made on behalf of someone who lacks mental capacity must be made in the person's best interests

5   All decisions should be aimed towards the least restrictive options available

Independence

The regulations governing BIAs seek to limit the role to people without a vested interest. Relatives of the Relevant Person (the individual who a BIA is going to assess to see if a DoLS is appropriate) are specifically ruled out, as are people with a financial interest. The regulations also set out that a local authority must select a BIA who is not involved with the Relevant Person's care or in making any other decisions about their care and treatment in order to strengthen their independence and freedom to act.

BIA's decisions are independent but it is the Supervisory Body (currently local authorities) which authorise the DoLS. This contrasts with a AMHP whose decision and duly completed paperwork is deemed as the legal authority to detain the person. The new LPS legislation due to be enacted in April 2022 will enhance assessors' independence to a small extent in that the decisions on the assessments they carry out will legally be their decisions. However, the Responsible Body (under the new legislation being local authorities and NHS Trusts) will make a decision about which assessments are complex and need assessment by an AMCP. The ones that they deem more straightforward will be assessed by non-AMCPs.

The Best Interests assessment

The Best Interests assessment is one of the six assessments undertaken when considering DoLS. Even if all the other assessments point towards the need for a DoLS the BIA must consider whether the proposed regime is in the best interests of the person and is both necessary and proportionate. This is designed to be an additional safeguard for people and to ensure considerations are wider than those around risk and mental capacity (Hubbard & Stone 2018). The term 'best interests' is not defined in the Mental Capacity Act 2005, but it is designed to be part of a more holistic assessment of all relevant factors. Case law points towards the need to consider what is in the best interests from the Relevant

Person's point of view[7].

Although the term 'best interests' is not defined in legislation, section 4 of the Mental Capacity Act 2005 states what ought to be considered when ascertaining what might be in a person's best interests. The BIA must consider:

a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by [the person] when [they] had capacity)

b) the beliefs and values that would be likely to influence [their] decision if [they] had capacity, and

c) the other factors that [they] would be likely to consider if [they] were able to do so

The BIA must also consider whether the person is likely to regain mental capacity and the views of anyone providing care or support to the Relevant Person on their care – including those with legal powers over their care.

The BIA:

In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of:

a) the person's age or appearance, or

b) a condition of [the person], or an aspect of [their] behaviour, which might lead others to make unjustified assumptions about what might be in [their] best interests.

[7] Aintree University Hospitals NHS Foundation Trust v James (2013)

Responsibilities

The Supervisory Body (local authority) is responsible for commissioning the six DoLS assessments following an appropriate referral sent by a Managing Authority (residential/nursing home or hospital). The DoLS assessment consists of the following separate assessments:

- Mental Health Assessment: to establish whether the person being assessed has a mental disorder within the meaning of the Mental Health Act 1983 (amended 2007)

- Mental Capacity Assessment: to establish whether the person has the mental capacity to consent to the arrangements made for their care or treatment

- Eligibility Assessment: to establish whether the person is eligible for the DoLS. The person meeting the criteria to be detained under the Mental Health Act 1983 (amended 2007) would make the person ineligible for the DoLS

- Age Assessment: to establish the person is aged 18 or over

- No Refusals Assessment: to establish whether an authorisation would conflict with other existing authority for decision-making for that person, such as an advance decision to refuse treatment under the Mental Capacity Act 2005 or a Lasting Power of Attorney

- Best Interests Assessment: to establish that the deprivation of liberty is in the person's best interests

The first assessment must be carried out by a Mental Health Assessor (an appropriate doctor). The mental capacity assessment can be carried out by the BIA or the Mental Health Assessor. The eligibility assessment can either be carried out by the Mental Health Assessor or the BIA (if the BIA is also an AMHP). The final three assessments must be carried out by the BIA, including the crucial best interests assessment.

Best Interests Assessor: Review of the literature

When the Best Interests Assessor (BIA) role was created in 2009 with the introduction of the Deprivation of Liberty Safeguards (DoLS) into the Mental Capacity Act 2005, much consideration was given to what this new role might look like in practice and what requisite knowledge, skills and values practitioners would need to build upon and acquire in order to complete best interests assessments as part of the DoLS process and legal framework.

At the time, existing professional legal processes that assessed a person's health and wellbeing in relation to decisions regarding deprivation of liberty were predominantly framed within the role of the AMHP under the Mental Health Act 1983. Constructions of risk and the health and safety of the person and others provided the legal frameworks for professional decision-making. Graham (2016) suggests that whereas AMHP decision making was for the most part reactive to any given perceived crisis, BIA decision making was principally based upon safeguarding the rights and liberty of people who were already being (or likely to be) deprived of their liberty by the particular Managing Authority. This implied that the BIA role was intrinsically about safeguarding the person's Article 5 rights, relating to liberty and security (Human Rights Act 1998), with the essential elements being the use of a procedure prescribed by law to authorise the deprivation, including recourse to an appeal process. Implicit in this is that care providers (Managing Authorities) should work towards measures that minimise restrictions on the person's liberty making it unnecessary for a BIA to consider deprivation of liberty, per se. The literature reflects this suggested sea-change from risk management to the promotion of autonomy.

Watt and Brazier (2009) focused on how DoLS might impact upon people who have a learning disability. They asserted that professionals undertaking best interests assessments must ensure that the rights and freedoms of people with learning disabilities are addressed. Graham and Cowley (2016) argue that a DoLS authorisation might afford people in certain care settings more rights and liberty than they had experienced previously.

Peer-reviewed journal articles, think-pieces, grey literature and books are saturated with examples of the use of case-studies to exemplify the challenges and tensions present when assessing whether a person is being deprived of their liberty. Literature suggests that discourse shifted from legal duties of applying legislation in practice to professional responsibilities of understanding a person's narrative, which Johnston et al., (2016) refer to as the 'on-switch' for evaluating best interests.

Biswas and Hiremath (2010) use a case illustration to outline the principles and processes involved in everyday clinical practice in the assessment of mental capacity to consent to treatment in accordance with the Mental Capacity Act Code of Practice. The authors demonstrate the value given to discussing the BIA role within the context of case study analysis. Several journal articles followed offering contextual opinion pieces in relation to professional good practice, knowledge, skills and values and what was considered to be a natural symbiosis with this new legal role (Griffith and Tengnah, 2013; Ruck Keene, 2012).

From the inception of the Mental Capacity Act, moving away from paternalistic cultures towards emancipatory practice created innovative opportunities for professionals to develop partnerships with people who used services in order to demonstrate values of equality and to challenge power differentials. The assessments undertaken by the BIA involve placing the person at the centre of decision-making and ensuring that the engagement maintains a sense of the person's past and present wishes and feelings (Mental Capacity Act, s4(6)) (Series, 2016).

The principles of the Mental Capacity Act, particularly that of taking all practicable steps to support people to make decisions, is reflected in the literature.

McKinnon (2014) explores the value and application of concordance within nursing practice by offering a discussion aimed at clinical settings and patient groups where this may have been viewed as impractical. The Mental Capacity Act has supported professionals to have a better understanding of working with people who use services in relation to shared decision making by enabling better communication and the supporting of people's decisions. McKinnon (2014) harnesses Cribb and Entwhistle's (2011) broader conception of shared decision-making and the notion of decision-making capacity as a continuum to argue that concordance can be pursued effectively in challenging settings such as childcare practice, mental health and the care of older people. Although McKinnon's article is nurse-centred, such themes are fed into wider literary and research considerations when offering topics deemed worthy of publication in relation to the Mental Capacity Act and best interests decision-making.

As the BIA role has developed and DoLS has become embedded in professional considerations, the literature reflects the growing interest in relation to how BIAs form judgments and make their decisions. Carpenter et al. (2014) used a factorial survey to identify what influences the judgements of ninety-three BIAs (three quarters of whom were social workers) which were gleaned from the responses to randomly generated vignettes. The authors found that coercive staff behaviour, as identified by BIAs, was the strongest statistical predictor of a deprivation of liberty judgement, followed by the resident's response. Other indicators of staff control, including the use of medication to reduce agitation, restriction of movement and family unhappiness with care were also significant.

The literature suggests that in addition to people's experiences it became necessary to reflect upon what drives BIA decision-making: this particular piece of research indicated that BIAs were responding to people's experiences of the outcomes of coercive care rather than reacting to any particular welfare concerns. It is argued that some professionals and academics were starting to establish the view that people were essentially being punished by being placed on a DoLS for coercive care regimes, perhaps even poor care regimes, indicating that if care regimes had changed to become more enabling and emancipatory then some DoLS authorisations may not have been required (Graham, 2016). Such opinions reinforced the view that DoLS primary function is to safeguard the rights and liberty of people receiving care and treatment and to hold care providers accountable for the delivery of that care and treatment.

The Cheshire West (2014) judgment[8] led to a significant increase in the number of requests received by Supervisory Bodies for DoLS authorisations. Romeo (2016) in Hubbard (2017) states that BIAs have attracted 'wide regard' since implementation. Hubbard (2017) believes that adult social work practice appears to have embraced its ethos and principles and that, anecdotally, it appears that thousands of BIAs have been trained since 2014 (linked to the Cheshire West judgement). It is fair to suggest that post Cheshire West the BIA role became one which was not only more needed, but also one of professional aspiration. The introduction in 2022 of the Liberty Protection Safeguards (replacing DoLS) and the Approved Mental Capacity Professional (AMCP) (replacing the BIA) has caused a surge in professionals wishing to undertake BIA training in preparation, thus enforcing increasing views of the BIA role as being an opportunity to reconnect with their values as the person whose professional role is to uphold people's human rights (Last Quango In Halifax (2017) in Hubbard (2018)).

The literature is scarce on peoples' and carers' experiences of the DoLS and best interests decision-making process, which presents a gap in the current research and literature. Grey literature, which includes articles and think pieces referring to professional best practice from second-hand narrative experiences, offers an opportunity to reflect upon the direct impact of a professional's intervention (Williams, et al., 2012). The lack of literature from those on the receiving end of BIA practice and DoLS decision making seems somewhat contradictory to Codes of Practice, policies, professionals' values and organisational advice which places partnership working and service user involvement and opinions at the centre of good practice. This may reflect the ethical difficulties presented when undertaking research with individuals who lack or may lack capacity.

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[8] Cheshire West (2014) judgment [P v Cheshire West & Chester Council; P & Q v Surrey County Council [2014] UKSC 19

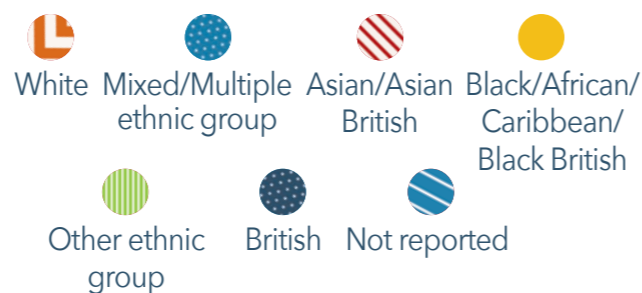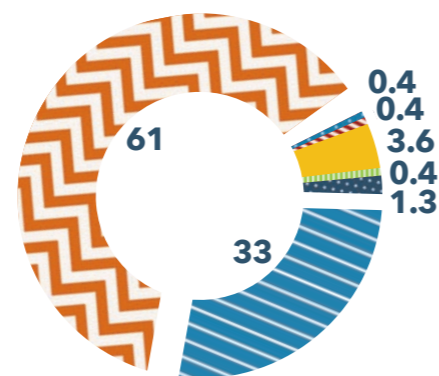# Best Interests Assessors: Findings from the survey

Survey demographics

The BIA survey had 248 completed returns, with background data as follows. To date there is no BIA-specific national data with which to weigh this representation.

The survey responses comprised 89% (221) social work respondents, 9% (22) nurses, 2% (5) occupational therapists and there were no psychologist respondents. Whilst being lower numbers in total than the AMHP survey the representation of non-social work respondents is higher than that of the AMHP survey. There is no national data against which to compare but the proportions do seem to have a very close resemblance to those found in research elsewhere (for example, Goodall and Wilkins, 2018).

The declared gender for BIAs was 133 females (54%), 35 males (14%), 1 person identified as genderqueer and 79 (32%) did not share this information.

BIA: What is your ethnicity?
(% responses)

- White
- Mixed/Multiple ethnic group
- Asian/Asian British
- Black/African/Caribbean/Black British
- Other ethnic group
- British
- Not reported

From those who answered the question about ethnicity, 61% described themselves as being White, 3.6% Black/African/Caribbean/Black British, 0.4% Asian/Asian British, 33% did not report and the rest were from mixed/multi-ethnic backgrounds or other ethnic groups.

Gender
(% responses)

- Female
- Male
- Gender queer
- Not reported
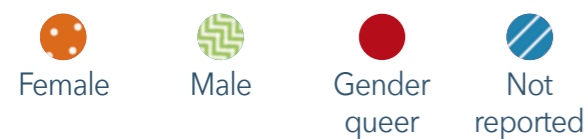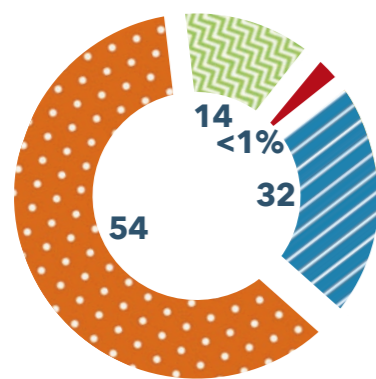
Age groups
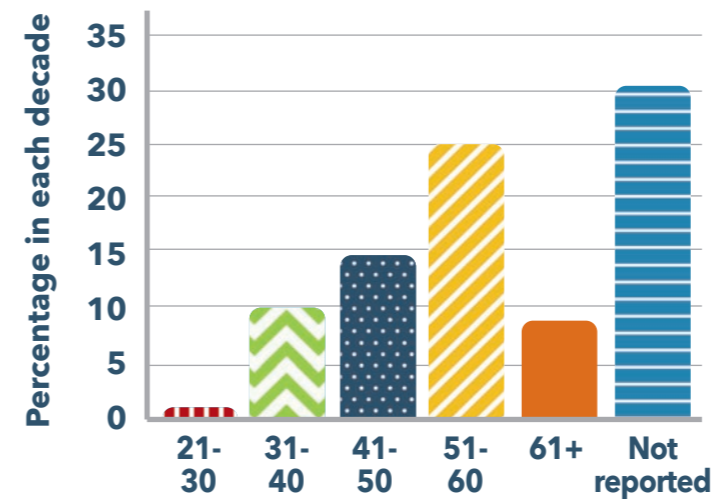
The peak age range for BIA respondents was between 41-60, with the majority of those who answered falling within this range. This is generally consistent with the AMHP workforce in that BIAs are also older than the social work population in general (Skills for Care, 2021).

Year of BIA qualification

How long have you been qualified as a Best Interest Assessor?
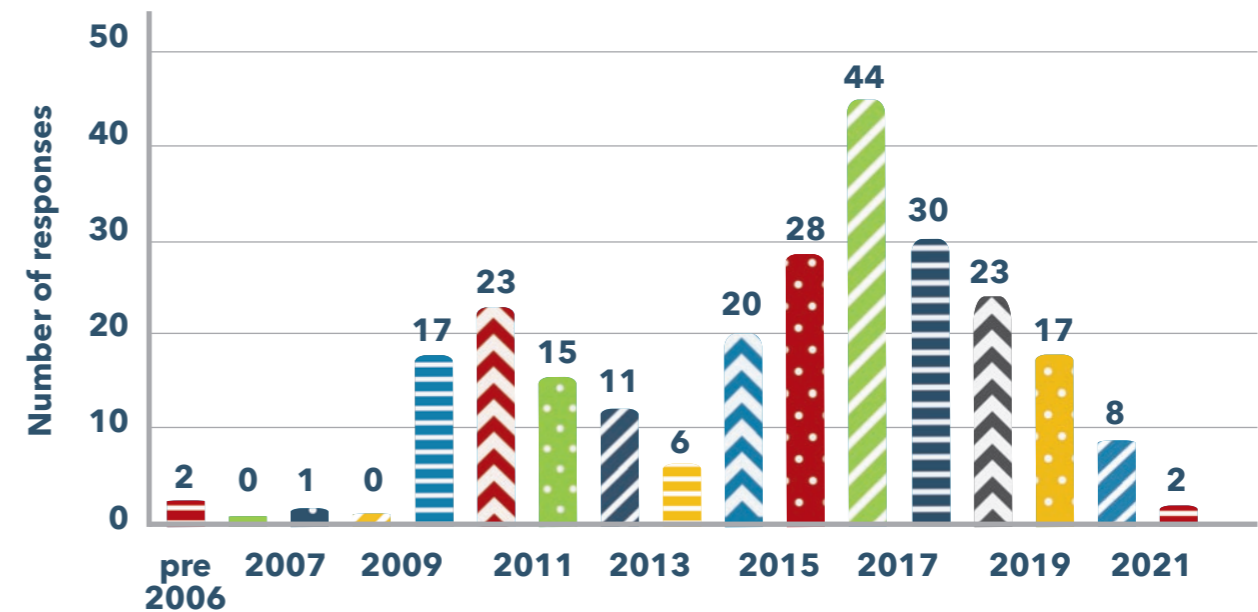
We asked BIAs to confirm their year of qualification so that we could understand how long they had been qualified and the graph illustrates that for this group most had qualified around 2015 – 2017 since when the rate of qualification has steadily declined. We do not know whether this is representative of the BIA picture generally.

Professional backgrounds in the workforce

Which professional backgrounds are represented in your workforce?
(422 responses)

Social Worker	236
Nurse	98
Occupational Therapist	73
Chartered Psychologist	2
Don't know	13
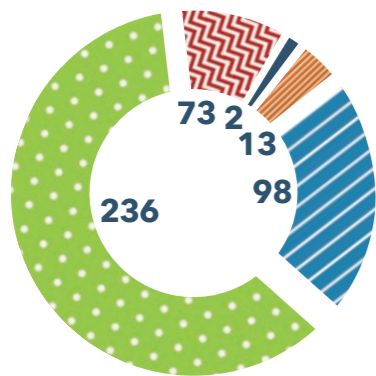
As expected social workers are very well represented but interestingly nurses were represented somewhat less than in the AMHP survey whereas occupational therapists were represented more.

BIA current employer

Who is your current employer?
(% response)

Local Authority 80 — Mental Health NHS Trust 7 — Self-employed independent BIA 9 — Other 4
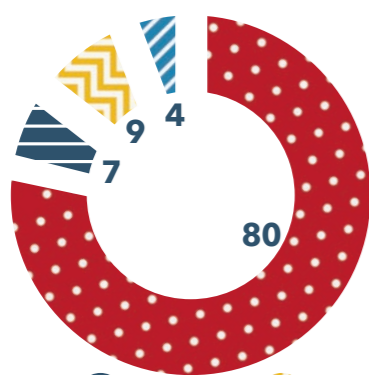
We asked BIAs to confirm who their current employer is and the majority (80%) were employed by the local authority, with 7% being employed by their mental health Trust. A higher proportion of BIAs than AMHPs said that they were independent and/or self-employed.

BIA as primary or mixed role

Is working as a BIA your primary role?
(% response)

No 57 — Yes 43

The majority (57%) of our BIA respondents said that being a BIA was not their primary role, a slightly higher proportion than for the AMHP respondents. For those whose BIA role is not their primary role, we asked how they define the remainde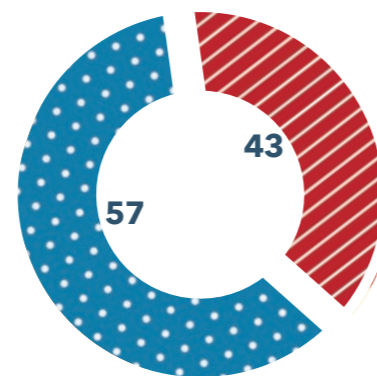r of their role. Responses to this were: 22% case management; 15% safeguarding; 10% duty or triage work; 13% Care Act activities; and 40% ticked the 'other'

category. It is evident from the focus groups that a range of DoLS team models exist around the country and this data reflects those findings.

BIA service configuration

How does your local authority configure its DoLS service?
(% response)

58 — Mixture of dedicated DoLS service and BIAs who have other duties
22 — Dedicated DoLS team which considers and undertakes all assessments
12 — BIAs who have other roles and work on a rota basis
8 — Other

- BIAs who have other roles and work on a rota basis
- Dedicated DoLS team which considers and undertakes all assessments
- Mixture of dedicated DoLS service and BIAs who have other duties
- Other

When asked how their local DoLS services are configured, 58% of our BIA sample said that their local authority had a mixture of a dedicated DoLS service and BIAs who did other work. Only just under a quarter of the respondents said that they had a dedicated DoLS team that did all their requested assessments.

BIAs and professional identities

We used the same questions for BIAs as for AMHPs to seek to understand professional identities. Respondents were asked whether they think that BIA is a profession, qualification, both or something else. The majority (44%) saw it as both, 23% saw it as a profession but nearly a third viewed it as a qualification only.

Do you think that being a BIA is a...?
(% response)

Profession 23 — Qualification 32 — Both 44 — Other 1

We were aiming to explore BIAs' interpretations of the way they perceive their work. We asked for explanations in the form of qualitative data to further explore this. Many had comments which were encapsulated as follows:

"Extension of my role to secure people's human rights; ensure independent scrutiny of a person's care arrangements"
(social work BIA)

"I see my work as a BIA as an extension of my Social Work profession. The skills used are the same, the information about the role is however different and needs regular consideration around law and aspects of being a BIA"
(social work BIA)

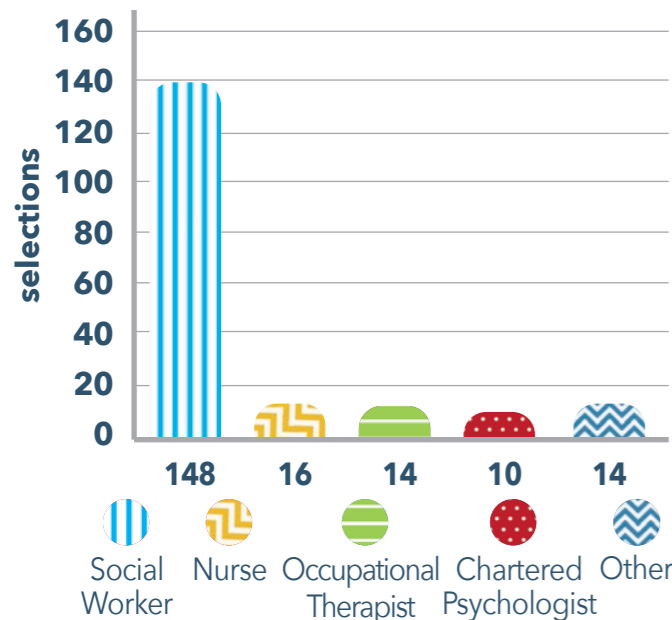We then asked BIAs whether they thought their own work was informed or influenced by the ethos and values of the regulated professions. Respondents were able to choose any that they thought applied, as well as being invited to make comments against each profession.

Do you think BIA work generally is informed or influenced by the ethos and values of the following professions?
(Social worker responses - 161)

Do you think BIA work generally is informed or influenced by the ethos and values of the following professions?
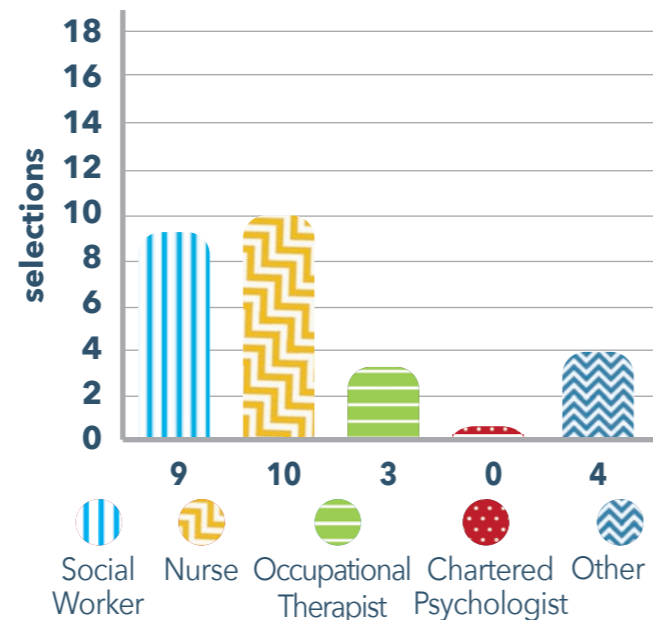(Nurse responses - 17)

There were 161 social worker respondents who made a total of 202 selections. 148 (92%) chose social work as informing and influencing BIA practice followed by 16 (10%) who selected nursing, 14 occupational therapy (9%) and 10 psychology (6%). 9% of the respondents selected 'other' which is explored in the qualitative data below. Of the 10 nurse respondents, 9 chose social work as informing and influencing the BIA role and all 10 chose nursing and 3 chose occupational therapy. 24% of the

respondents selected 'other' which is explored below.

Of the 4 occupational therapists who responded 50% chose social work, 50% chose nursing, 100% chose their own profession, 25% psychology whilst no 'others' were selected. The data, therefore, generally indicates that BIA social workers and occupational therapists are more likely to see an affinity with their own professions than nurses who saw a broader spread.

What social work brings to the BIA role

Respondents believe that social work connects well with the BIA role, with an emphasis on safeguarding, person-centred practice and self-determination. The social model and a holistic view of the service user were clearly articulated:

"Social workers are able to identify a rounded overview of needs, capacity and best interests [...] This is something that we do daily. We are also aware of monitoring safeguarding concerns, perhaps when we visit a home, and are used to speaking with families and gathering all other professional views together"
(social worker BIA)

There were more comments about social work than any other profession and these indicated the influence of a social model of understanding illness and the importance of the social perspective within BIA practice. Many respondents said that they thought that social work had a clear affinity with the BIA role. A small number of nurses thought that their own practice was becoming more attuned with social work ideas because of their time as a BIA. A nurse BIA believed that:

"The values and ethos of social work are reflected in this role [...] Empowerment, principles of social justice, human rights providing vulnerable people with a voice, addressing inequalities, determination, supporting people's right to choice and involvement in their life, challenging discrimination"
(nurse BIA)

There were a wide range of qualities and values attributed to social work's contribution to the BIA role. Key social work tenets of social justice, challenging oppression and discrimination, advocacy and empowerment featured in a number of responses.

A strong theme was the idea of putting the person at the centre of the process, using concepts such as self-determination, person-centred practice and looking for the least restrictive way forward through

"trying to ensure that any restrictions that are in place are only those which are necessary to prevent the person from coming to harm"
(social work BIA)

The belief that safeguarding was key to the BIA role and that this would involve challenging other professionals also featured in some responses.

One respondent commented on the importance of empowerment which happens:

"through promoting social justice, upholding that nobody should be deprived of their liberty without the appropriate legal framework in place [...] [and accepting] that the person is often an "expert" on their situation"
(social work BIA)

A small number of people suggested that the law, the code of practice and the BIA competencies influenced their BIA practice. A person's human rights was also a frequent feature. Given that we were asking BIAs specifically about values and ethos, it was noticeable that there were fewer references to a shared, specific value base than there were for AMHPs. It might be that this is still emerging in the BIA community and is yet to be as consolidated as it is in the AMHP world where there is a clearer coalescing around a shared value base. Reasons for this are speculative but it could be around the fact it is a newer role with different training models, aspects of peer engagement or a broader professional spread since the inception of the role.

This does not mean that values and ethos were not important to BIAs. However, the majority of responses talked about concepts and theories as being key to their values. One respondent firmly equated the BIA role with social work practice by stating:

"It is more like proper old-fashioned social work practice where you use the skill set. Not just ticking boxes"
(social work BIA)

Another respondent said:

"I see my work as a BIA as an extension of my social work profession. The skills used are the same [however the knowledge] is different and [it] needs regular consideration around law and aspects of being a BIA"
(social work BIA)

Generally, aspects of social justice and advocacy, as well as a high level of legal literacy, were clear indicators of the contribution of social work to BIA work.

What other professions bring to the BIA role

The data here is somewhat limited as some were unable to comment on any profession other than social work as they had not met or did not know of any non-social work BIAs.

Nurses as BIAs

A small number suggested that nurses might not be confident in working around mental capacity. One nurse had their own general reservation:

"[Social work] is much more forward thinking and prepared to challenge in terms of mental capacity. I don't believe the nursing profession prioritise, or are as confident, regarding mental capacity, as much as the social work profession"
(nurse BIA)

However, nurses were frequently seen as offering a holistic and person-centred approach to the job and the organisational knowledge and familiarity they bring was seen as being important. Overlapping themes were apparent from both social work and nurse BIAs. Promoting dignity, upholding decent care standards and having an anti-institutionalisation principle were present

in the responses. The specialist knowledge that many nurses acquire within their professional practice and training featured highly, with some mentioning knowledge of neuroscience, medication and physical health problems as a strong contribution to the tasks that BIAs carry out:

"I think having healthcare experience is valuable when determining the effect of confinement on an individual - both physically and psychologically. I think a nursing background ensures the BIA is attuned to care standards in a way that shines a light on areas where institutionalisation is evident, or where there is a lack of a person-centred approach"
(Nurse BIA)

"[Nurses have] great knowledge and input around health issues, medication and recommendations about behaviour issues"
(social work BIA)

A number of comments indicated that nursing was a good match for the BIA role. One social work BIA suggested that nurses might be focussed on a medical model that might hinder their BIA work, but this suggestion was far less prevalent than in the AMHP survey. One nurse AMHP talked about the Nursing and Midwifery Council code of professional practice as being well aligned with BIA values:

"As a nurse the Nursing and Midwifery Council codes are followed throughout all my practice, which includes the BIA role. I believe this ensures I am not biased and keeps the individual at the centre in any best interest decisions when assessing whether the deprivation is necessary and proportionate to the risk of harm. It also ensures I act within the legal framework. The BIA role is an extension to my nursing role and part of my own learning and development as a professional"
(nurse BIA)

This suggests the nurse identifies with the BIA specialism and, as with some of the social workers' responses, views the role as an extension of their professional identity. There was an understanding of the holism of the work generally:

It would be perverse to identify an holistic view and then discount the clear links to health and the role of nursing influences within concepts of wellbeing and my reliance on input from nurses in conducting assessments
(social work BIA)

Occupational therapists as BIAs

Occupational therapist BIAs appear to be small in number from our survey which would limit the number of responses. They were, however, also thought of as using a biopsychosocial and holistic approach to their work. Their particular knowledge of equipment, mobility issues and how to help people function in their lives were seen as well-matched to the BIA role.

Promoting independence and looking for less restrictive options were areas of their usual practice that occupational therapists could bring to the role. A few respondents thought that occupational therapists were just as suited to the BIA task as social workers and nurses:

"The core philosophy of occupational therapy is about use of client centred and holistic approaches to improving quality of life, maximising independence, and facilitating participation in day to day activities chosen by the client. The Mental Capacity Act 2005 is embedded in every aspect and area of occupational therapy practice"
(occupational therapy BIA)

There were positive comments including that specialist knowledge of equipment and aids that can help reduce restrictions allowed people more freedom. A number of people reported that occupational therapists were good at writing well-structured reports and used a solid analytical approach.

"There are times when an occupational therapy perspective has highlighted specific areas of care that may be too restrictive, that a social worker may have otherwise missed"
(social work BIA)

"Occupational therapists have a very good understanding of the impact of physical equipment and likely restrictions of these, as well as how equipment can support people to be more independent and less restricted"
(social work BIA)

"Good understanding around support needs and also able to challenge the managing authority around some of their restrictions and practices"
(social work BIA)

Psychologists as BIAs

As there are fewer psychologists who are also qualified and work as a BIA our data was limited. It was suggested that they might look for the least restrictive outcomes of assessments and use a psychosocial approach. Again, it was commented that they would have a similar ethos to social workers and nurses.

"Psychosocial theories influence our understanding of human behaviour/thought and thus the impact of a deprivation of liberty"
(social work BIA)

A small number of responses referred to psychiatrists impacting on BIA practice, although there was no discussion about whether this was a positive or negative influence. Where BIAs were invited to comment on the influence of other professional influences a small number listed lawyers and the legal profession as important to BIA work.

BIAs' professional identities: real or illusory?

Overall, the general perception is that there is little difference between the regulated professions in terms of the way BIAs practice. In relation to social work BIAs, there was an indication that they can lose sight of what the BIA role is about and veer too much into case management instead:

"Social workers will sometimes lose sight of the assessment purpose and try to care manage on [the] individual's behalf"
(social work BIA)

"Some of my social work colleagues can try to case manage cases which is not the role. Boundaries can become blurred"
(nurse BIA)

Further, in relation to decision-making and the ability to be assertive:

"I have […] met some social workers who have felt intimidated by the s12 Doctor who may not agree with their decision"
(social work BIA)

One occupational therapist observed that social work BIAs can be 'too patriarchal in general'.

In relation to nursing, although on the basis of fewer responses, opinions were mixed as to what nurses brought to the role.

"The independent BIAs that we have used, who have nursing backgrounds, have been less challenging of restrictions"
(social work BIA)

A small number of social work respondents suggested that nurses could be too adherent to a 'medical model' of illness, although this was seen as beneficial in respect of knowledge of physical health problems. A few respondents suggested that nurses might be too risk averse for the role:

"Nurses can be risk-averse, they can also take a 'medical model' approach and get too bogged down in care standards rather than the promotion of decision-making and autonomy"
(nurse BIA)

There were still fewer responses for occupational therapy and many said that they had never seen an occupational therapist BIA. A small number thought that occupational therapists may use a model of illness and disability that was too medical and one social worker BIA added:

"I have experienced some difficulties with occupational therapists, but they were acting as a signatory rather than as a BIA. Their approach was very detail orientated and they were unwilling to accept advice"
(social work BIA)

There were very few responses in relation to the influence of psychology and the overwhelming response was that people had never seen a psychologist BIA. There were some speculative comments about what psychologists might be like or how psychologists were in other roles but there were no clear themes.

Overall, a theme that resonated very strongly with the AMHP workforce was that the capacity to challenge and to be an assertive advocate for the person was a crucial part of the work.

The challenges of the BIA role

Lack of time to do the work

We asked BIAs which aspects of the work (if any) they found the most challenging. Working within the DoLS system appears to have many significant challenges. As with AMHPs, the biggest single issue mentioned by BIAs was the lack of time to carry out good quality assessments. Many suggested that they had to do DoLS assessments in addition to their regular caseload, already increasingly pressured, with some reporting that they had to complete them at weekends and in the evenings. A number thought that managers did not understand the complexity of the work and the time needed to complete them properly. A few respondents commented that the paperwork could feel overly bureaucratic and lengthy.

Lack of power in the BIA role

BIAs expressed dissatisfaction that the BIA role lacks real power which manifested itself in a number of ways. Some believed that they often could not enforce conditions on care homes, with a few reporting that attempts to use official channels such as safeguarding or referral to the Care Quality Commission did not result in the challenge to the care homes that they expected. Many reported that they struggled to get other professionals, care homes staff or hospital staff to see the importance of the role and to provide crucial information in a timely fashion:

"One frustration is when recommendations are not followed up. The BIA role does not come with the power to make actual changes, just to recommend how someone's situation could be improved. In some circumstances, a lot of time can be taken in following up why these recommendations have not been actioned and persuading/ negotiating to move things forward"
(social work BIA)

Lack of resources and least restrictive options

A key part of BIA practice is to look for the least restrictive option to keep people safe while enabling people to have as much self-determination as possible. This looks to be a very difficult task with many respondents stating that there was a lack of resources and meaningful alternatives to the care home or hospital deprivation of liberty. BIAs' frustrations were apparent,

with some respondents believing that the role of the BIA was not independent enough and with pressure being put on them by managers to authorise longer time periods than they felt comfortable with. In a small number of cases BIAs thought that the detention under DoLS was seen by managers and managing authorities as a 'done deal' when they started the assessments.

COVID-19

BIAs expressed the emotional toll on themselves of having so many people in care homes become very ill or dying as a consequence of COVID-19. The problems of homeworking caused difficulties in carrying out good quality assessments via remote working, with many people highlighting how important it is to 'use our senses' in person to get a full picture of the person they are assessing. COVID-19 restrictions also appear to have put pressure on BIAs as being unable to get the information they need from care homes.

As with AMHPs, several respondents commented on working from home due to the COVID-19 restrictions as being a negative factor when reflecting on their mental health and emotional wellbeing. They found that having peer support was valuable, and at times acted as a debrief following a difficult piece of work.

Working with others

A key finding was the problems BIAs had in dealing with other people. Trying to explain the complexities of mental capacity and DoLS to families was frequently commented upon. Working with families who were in conflict with the decision or even with each other was a significant issue. These BIAs also had a lot to say about other professionals too, with many claiming that health and care professionals, care home staff and hospital employees all regularly struggled to understand DoLS and capacity. A number of comments were received which suggested that the BIA role was often one of educating people on the law and requirements, all of which is time consuming. A smaller number of people commented on poor practice in care homes and hospitals being a problem, including not adhering to legal requirements under the Mental Capacity Act:

"Even though [it] was introduced a few years ago now some professionals in health and social care settings still do not understand DoLS, the role of the BIA and the Mental Health Assessor and therefore can at times misinform families which causes a lot of misunderstanding and lack of trust"
(social work BIA)

BIAs' access to information

A significant number of respondents highlighted difficulties in getting enough information to make a reasoned recommendation. This included many independent BIAs not being allowed access to the care records held by local authorities. Given that some local authorities either use independent/agency BIAs on a regular basis, or rely almost completely on this group of BIAs, this is a worrying finding. Getting full and timely information from care homes, hospitals and other care management or health colleagues was seen as problematic, with some commenting that these professionals often felt reluctant to share information with outsiders. Reliable information is key to accurate assessments, so this is concerning.

Decision-making and the law

Challenges are encountered at some of the key decision-making points within the DoLS process. The dilemmas in assessing whether a person has the capacity to make a certain decision was a major issue, especially around either fluctuating capacity or 'borderline' capacity decisions. Alongside this were difficulties in balancing both freedom and safeguarding concerns and working with the Mental Capacity Act/Mental Health Act interface. These are already inherent challenges in the process, which are exacerbated by pressures to complete the work more quickly despite frequent problems with the flow of information.

Some BIAs found the process of going to the Court of Protection for cases such as dealing with objections a lengthy, complex and slow process. Four BIAs found the need to keep up with case law posed problems for them:

"Very bureaucratic process; cumbersome appeals process. We are often reassessing people whose cases should have been considered by the Court of Protection, but this hasn't been taken forward. Overlap with Mental Health Act is problematic - different professionals have different views on this"
(social work BIA)

Health and wellbeing

Whilst we do not have the same volume of data or longitudinal knowledge of the impact of BIA work on stress, burnout, recruitment and retention, we wanted to know more about the extent to which BIA work is affected by these issues to enable a current comparison.

To what extent does your BIA work affect the following?
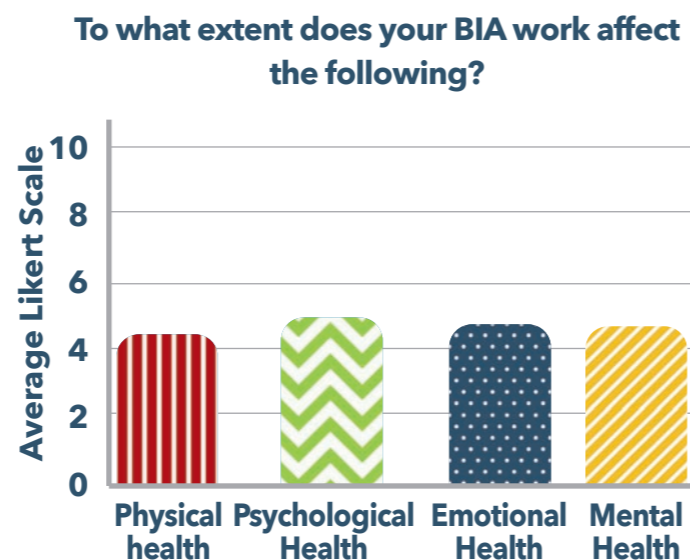
The health impacts were broadly similar for BIAs and AMHPs. Allied to this question, we asked BIAs what, if any, were the significant challenges that created stress or an impact on their overall health and wellbeing.

Two main factors creating stress: conflict and workload

Although some BIAs stated that the work itself was less stressful than regular case management and Care Act (2014) work it nevertheless appeared to have an impact. There seemed to be two particularly stressful areas: the ways in which the work can bring BIAs into conflict with others and the level of workload.

Conflict

There were several ways in which BIAs' stress was derived from conflict with others:

"Across the department the Mental Capacity Act has not received the same level of attention/implementation as the Care Act e.g. to create consistency. Conflict can be stressful, for example, often challenging other partners in a constructive way to ensure [the person] is safe, happy and well"
(social work BIA)

"I can find the role emotionally draining at times, especially when a case has been very difficult with varying views from different people such as family members in conflict"
(social work BIA)

Workload

As with AMHPs, a number of people who combined their BIA work with other duties suggested that caseload allocations created stress and anxiety and that it was difficult to manage the BIA role in addition to their main role. It is difficult to understand for both AMHPs and BIAs how part-time or full-time role allocation has an effect in either a positive or a negative direction.

Personal conflicts were highlighted:

"I think the challenges of workload and expectations can be really high. Not always allow[ing] time for practitioners to reflect and fully conclude a piece of work. This may often feel as though you are just a turning cog to make the wheel move. This goes against my own personal values so can cause a lot of conflict internally, which impacts on mental health/psychological wellbeing"
(social work BIA)

In general far fewer BIAs than AMHPs talked about the emotional impact of the role, its 'rawness', trauma or their own emotional labour. Some however did describe the ways in which they can personally identify with the work:

"I am 62 (and in general good health) and I am assessing people who are younger or not much older than I am. I am soon to retire, but the last couple of years has brought home to me the fragility of mind and body when a person gets older. I have dwelled on this a bit too much, I fear"
(social work BIA)

Rewards of the BIA role

Many BIAs, as was the case with AMHPs, found the inherent autonomy of the role rewarding. In contrast with AMHPs, however, some BIAs perceived a rewarding 'work-life balance', but this was apparently due to a perception of not being 'micromanaged' in the way that their non-BIA work is experienced.

A significant number of people said that the role was not stressful and did not affect their health:

"I don't feel the BIA/DOLS work affects my health any more than other similar work in the area (social work). There are always times and challenges that are stressful, but I think this is true for social work as a whole" (social work BIA)

"I enjoy the work which I undertake and feel well supported in the team and the local authority. I feel my views are valued within the team and wider professionals. I do not find the role stressful compared to previous roles" (social work BIA)

Leadership, support and supervision

We asked BIAs if they have a dedicated BIA/DoLs manager, with 87% stating that they do and 13% not.

What profession is the BIA/Lead manager?
(% response)

| Social Worker | Nurse | Occupational Therapist | Other |

7
2
8
83
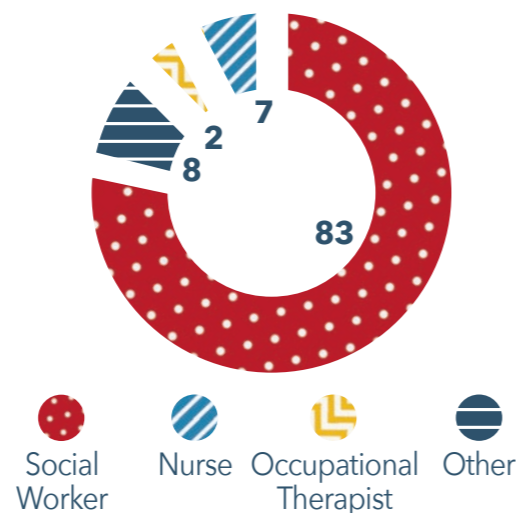
When asked to identify the profession of the BIA Lead/manager, 83% were social workers whilst 7% of BIA leads were from the nursing profession. This is a greater nurse presence at leadership level than in the AMHP workforce, but is generally commensurate with what appears to be a higher number of nurses in the BIA workforce more broadly.

Do you receive professional BIA supervision?

When we asked if BIAs receive professional supervision, slightly less than half (45%) confirmed that they do. There were a small number of additional comments around informal supervision and obtaining supervision from other

Do you receive professional BIA supervision?
(% response)

| Yes | No | Blank |

25
40
45
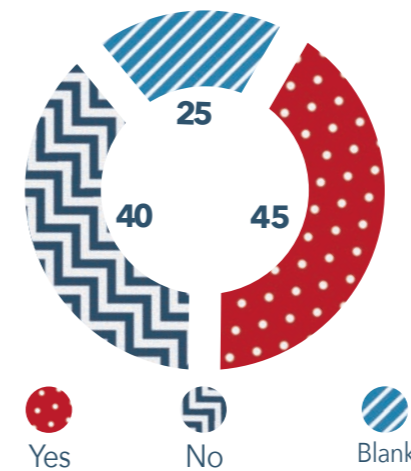
sources (such as university lecturers). A small number reported that the person that was supposed to supervise them was not a BIA. 40% of respondents said that they do not receive professional BIA supervision – an area of obvious concern.

BIAs were then asked to rank the support strategies they found most welcome or effective. They were asked to rank the most welcome or effective (1) to the least welcome or effective (5).

Which are the most welcome or effective support strategies?

Number of responses

Rank: 1=Most welcome, 5=Least welcome

Legend:
- Dedicated supervision
- Peer support
- Team meetings
- Training
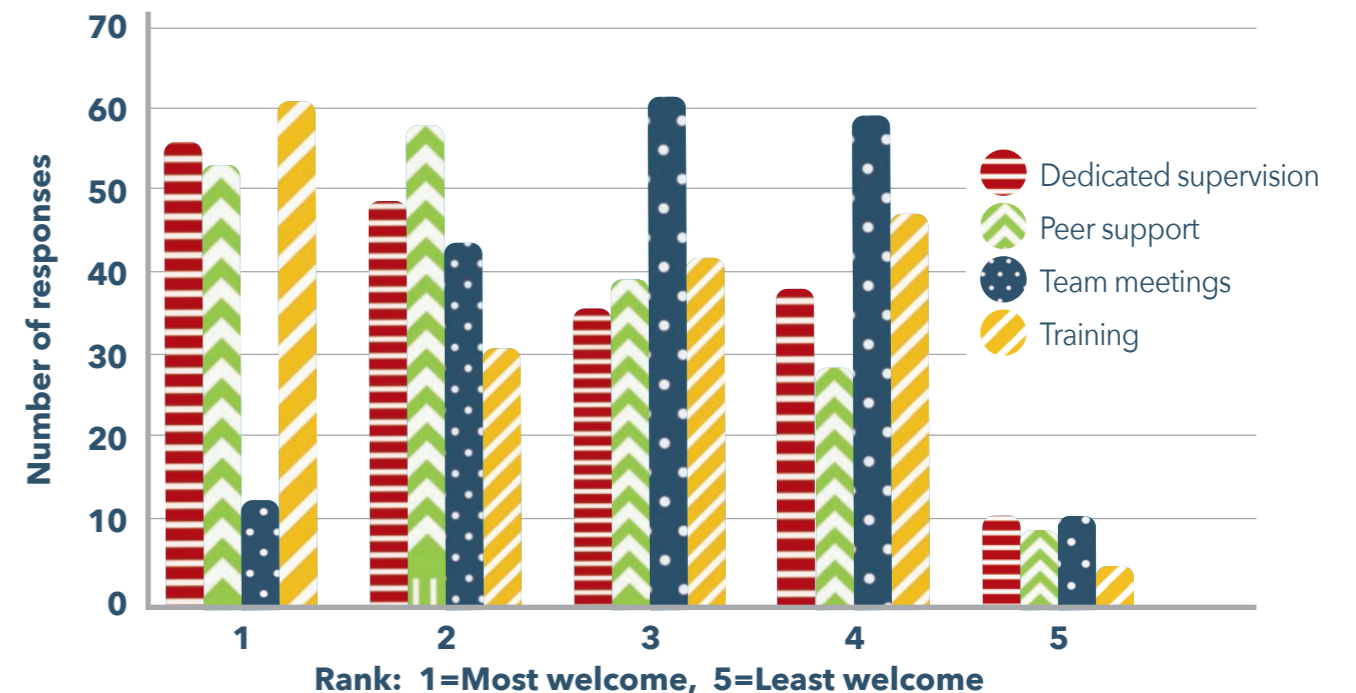
The preferences here were less clear cut than in the AMHP survey but a clear and interesting difference between the workforces is that BIAs place a higher value on training, with the majority saying that this is their most welcome strategy. This may reflect the more rapid and detailed changes in case law and legislation and a need to keep up-to-date, it may be a facet of the work itself, it may be that BIAs have an overall sense of more independent working, with less import attached to peer support, and it may also be to supplement dedicated supervision which is often lacking. Peer support is valued as is dedicated supervision which highlights the importance of the fact that 40% of BIAs report not receiving professional BIA supervision.

BIAs and professional regulation

To further examine BIAs' perceptions of the support they receive we asked them who their professional body is. We used a free text approach so that participants could apply their own understanding and interpretation around regulation.

Who is your professional body?
(182 responses)

There were 182 responses to this question. 160 social workers responded, and of these 139 stated that their professional body was Social Work Engla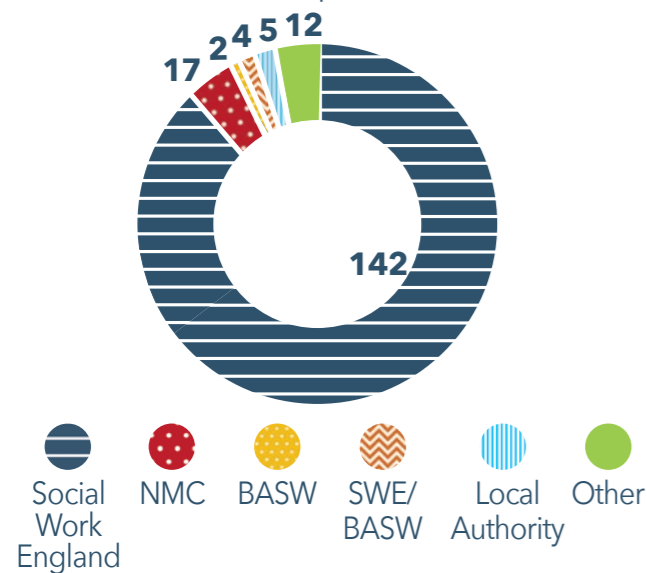nd. Other responses included the local authority, Social Work England and the British Association of Social Workers (BASW) combined, BASW alone, the Health and Care Professions Council (HCPC) and Social Care Wales. The 'other' category included 4 unclear answers and 2 who were unsure or couldn't remember.

18 nurses responded to the question and all but one said their professional body was the Nursing and Midwifery Council (with the other saying the Royal College of Nursing). 3 occupational therapists

responded, with one saying the Royal College of Occupational Therapy (RCOT) and British Association of Occupational Therapy (BAOT) combined, 1 RCOT and HCPC combined and 1 saying RCOT alone. As with the AMHP survey, respondents generally gave only one answer and there is an indication that BIAs are similarly unsure in relation to professional body representation and regulation.

Education and training

We asked BIAs if they think that their training and education prepares them adequately for the BIA role.

Do you think current BIA training and education prepares trainees adequately for the role (in terms of content and placement)?
(% response)
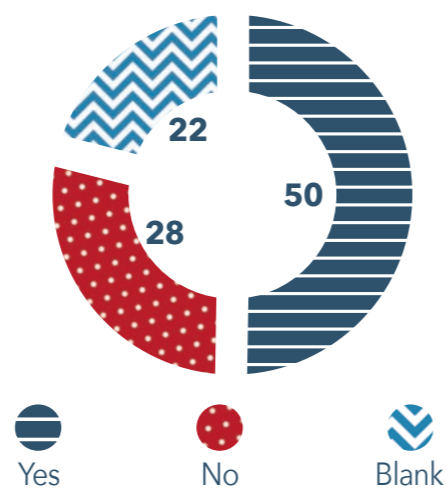
Only half believe that the current range of BIA training and education prepares them adequately for the role. More than a quarter (28%) stated definitely that it does not and a further 22% did not respond to the question. This is a worrying finding

suggesting a shortfall in education and training provision.

When asked to explain their responses, many suggested that the courses could be longer. People thought that the five- or six-day initial training course was not long enough to prepare them for the role, with some suggesting that it should be akin to the AMHP courses which have a longer duration. As with AMHPs the inconsistent approaches to training across differing academic institutions was noted.

Some suggested that there should be a mandatory period of time spent in practice during training to ensure there was a clearer application to practice. A significant number thought that there needed to be more shadowing of BIA assessments incorporated into the courses to add those practical experiences:

"I do not think the five days of training adequately prepares people for the role. The role of the BIA is complex; you have to be up to date with relevant case law and aware of your accountability as a professional. When you compare BIA training to AMHP training, there is a stark difference in time spent preparing for the role, shadowing, being supervised in practice and the amount of academic work required. I think any AMCP training should consider extending the amount of time studying and shadowing"
(social work BIA)

A common suggestion was for a stronger emphasis on the legal requirements in theory to their practical application. Some suggested that there could be assessment or teaching that addresses the ability to complete the required forms or to carry out an assessment. Others stated that more knowledge of the DoLS process was needed, with at least some kind of test of the law. A few respondents discussed some organisations' weaker commitment to training their staff, with insufficient study days allocated or with people being forwarded for training with little preparatory training or experience around the Mental Capacity Act:

"The current training appears to be little more than a rapid run through the process, with little time to explore the more complex elements of the work such as disputes with family, the threshold of objection, borderline capacity assessments, identifying a person's wishes and feelings in the context of their cognitive impairment, conflicts of interests between family/care team/resident"
(social work BIA)

There were references to national inconsistencies in the delivery of BIA training, with a suggestion that training doesn't appear to have evolved since the first courses:

"Training is inconsistent across the country. In my region, although the training is good, it was a five-day course in 2008 when there was no case law. Thirteen years later it is still a 5-day course, but those studying it have to get to grips with a vast amount of case law and complexity"
(social work BIA)

When asked what works well about the training, the majority of responses indicated that the teaching on their BIA course was good, relevant and engaging. They thought that the shadowing of BIA assessments they did on the course were positive learning experiences. The most helpful areas were said to be legal literacy and seeing examples of BIA work and case studies. A significant proportion of the sample highlighted that peer support (both classroom-based and in the workplace) were useful to their learning, with mentoring following close behind. Some respondents found that the assignments were a useful part of their learning as was spending time away from their office to study. Effective training was summarised as:

"[…] lots of practice of going through form 3. We were taught what each assessment meant, why each assessment needed doing and how they fitted together. I had to shadow a BIA in practice. This supported me to fit what I was learning into practice without having to cope with actually doing it at the same time. We had to do lots of thinking about realistic options for the person within the best interest process. We also had to think a lot about what was necessary to support someone to mitigate against the risk of harm and was it proportionate. Case law was handy to know because it helped me think about the bigger picture and what mistakes had been made in terms of practice in the past"
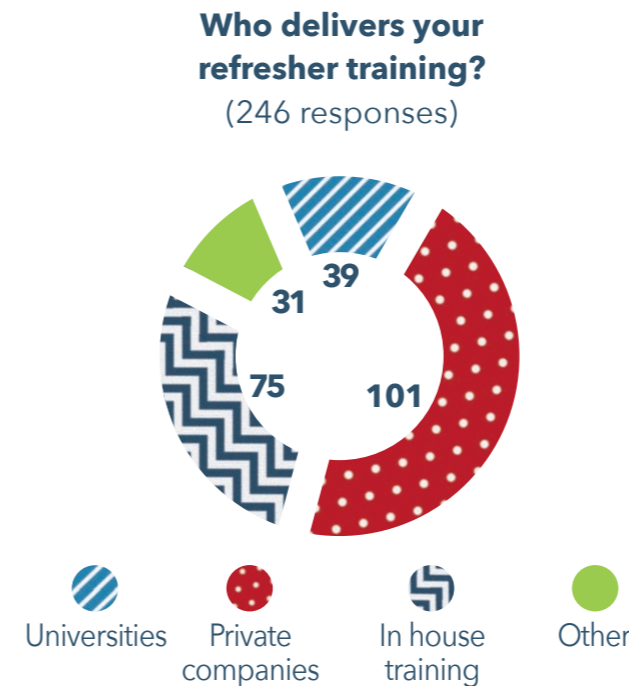(social work BIA)

Many respondents referred to a solid practice background and knowledge of the Mental Capacity Act as being essential prior to undertaking BIA training:

"The assessment was directly linked to practice as it was the completion of a form 3 (to include referencing case law etc). For me this was a very meaningful way to assess as it really supported me in preparing for the role as BIA […] There are gaps in social work training, nurse training, doctors training etc with regards to the Mental Capacity Act and preparing professionals for practice in that area [and] this will ultimately impact on that professional's ability to practice well as a BIA"
(social work BIA)

BIA refresher/CPD training

We asked BIAs who delivers their refresher or CPD training. They were asked to select all that apply.

Who delivers your refresher training?
(246 responses)

- Universities
- Private companies — 101
- In house training — 75
- Other — 31
- (Universities) — 39

Refresher training, according to our sample, is delivered by a range of providers including local authorities, universities, law firms and private providers. An example of good practice was highlighted:

"In our local area, we have a range of organisations working together, such as independent social enterprises and the local Clinical Commissioning Group. Our refresher training includes a mix of private training companies and guest speakers, such as those in the legal field. We also have in house training which can be accessed as a refresher (to all staff, not just BIAs) which is delivered live, as well as other training resources such as a YouTube channel, e-newsletter sharing case law summaries, signposting to other relevant resources etc"
(social work BIA)

Many of the comments about their current refresher training were positive. Overall, the emphasis was on this being legalistic:

"Our annual mandatory training is excellent and really does sharpen my practice. It is presented by lawyers and is really helpful in understanding the role and expectation of the CoP"
(social work BIA)

The areas where it was thought that more emphasis could be placed were case law, what LPS is going to look like, report writing, the Mental Health Act 1983 (amended 2007) and the basics of carrying out mental capacity assessments. A number of respondents thought that their refresher training was insufficient and not frequent enough. On the whole, however, and as confirmed by the discussion above, refresher training does seem to be the most welcome and valued source of support for BIAs. That it appears to have a clear legalistic emphasis is also consistent with BIAs need to keep up-to-date with legal developments in a way that is not the case with AMHPs.

Dual specialisms: BIAs who are also AMHPs

We asked BIAs whether they are also an AMHP, with 14% saying that they were.

Are you also an AMHP?
(% responses)

14 61
25

Yes   No   Blank
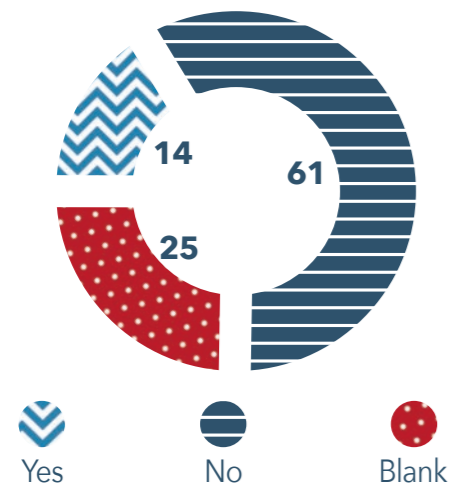
Of these 14%, when asked how their AMHP role relates to their BIA role, the responses overwhelmingly showed that they believed that the two roles complemented each other well. This was largely due to the fact that the AMHP role helped BIAs understand the Mental Health Act/Mental Capacity Act interface much better:

"I think it is very helpful to have a good working knowledge of the two specialisms because there is so much overlap and the interface can be complex for non-dual trained colleagues to understand"
(social work BIA)

"It gives me confidence to deal with the interface […] AMHPs who are not BIAs put a lot of emphasis on avoiding the use of the Mental Health Act […] and perhaps at times forget to think about the fact that a deprivation of liberty is already occurring and a [legal] framework […] needs to be used
(social work BIA)

One BIA did highlight subtle areas of difference:

"Being both helps you to see that although the roles are very different, they are equally complex. [Yet the] AMHP role is afforded much more status, even though the BIA role offers much more opportunity to have impact on quality of care and human rights"
(social work BIA)

Another social work BIA said that their previous AMHP work had led to an ability to manage stress better.

The majority of the views expressed here were consistent with the AMHP survey, although this is to be expected since it is highly likely that those with the dual qualification completed both surveys.

We asked which BIAs were intending to convert and continue to practice as an AMCP:

Are you intending to convert and continue to practice as an AMCP?
(% responses)

11 64
25

Yes   No   Blank

Two-thirds are planning to do so, which is consistent with the survey and focus group data highlighting how many saw positives in the role and enjoyed the work. The overwhelming response was that people like the role and think that it is valuable work to be doing. Some said that it felt like 'real social work' compared to their normal care management roles and many saw it as an essential role:

"I feel passionate about the rights of those who are unable to consent to their care and accommodation arrangements. I feel it is a valuable role as part of the legal framework to safeguard some of our most vulnerable people in our society"

A significant number said that they would convert to AMCP because their employer expects them to or their ongoing employment would be conditional upon

doing so. A small number wondered if their employer would allow them to convert, which reflects the differing nature of team and organisational structures in the workforce.

Some who would like to convert expressed worries about what the LPS regime would be like and questioned whether the role would be strong enough or have enough power, authority or impact:

"[There is] no clear role. No clear responsibilities. The role is to come in and manage all the assessments where there are challenges or disputes and I don't want a role like that. I am really unhappy with hospitals being responsible for their own assessments and authorisations - they are poor at MCA practice as it is - and there will be no outside checks - unless they refer them themselves. I don't like the role of the AMCP"
(social work BIA)

The biggest reason given for not converting to AMCP was retirement or imminent retirement. A small number said that they were changing jobs or were not yet sure what the LPS role was going to be.

People's experiences of BIA interventions

One person volunteered to be interviewed about their experience of an assessment of capacity. The BIA was a social worker. The person generally was of the view that local authorities have a lot of power and that, in fact, it is too much power to have as it limits people's choices. Whilst they liked the BIA personally and she asked lots of questions in different ways and had a good discussion, the person was generally unhappy with the level of control given to BIAs by local authorities. They did not see a difference between social workers and nurses if they both worked on behalf of the local authority.

The person we interviewed was clear that people should be treated as individuals and that sometimes this does not happen. As a group, people with disabilities are treated as all having the same problem when, in fact, they have very different needs and abilities. It is important to take time to get to know someone and to speak to any friends or relatives that may be able to speak on their behalf. This person believed that it is very difficult, if not impossible, to undertake a meaningful assessment of a person's capacity if they do not know them very well. Considering the power and control that is part of the role of a BIA, along with the implications of making critical decisions, for example around someone's finances, it is wrong to not be very careful about what you are doing.

Experiences of family members of people receiving a BIA intervention

We interviewed two people who had experience of a family member receiving an intervention from a BIA. Both BIAs were social workers and both family members experienced a worker who communicated well, with one commenting that it was 'discreet and non-threatening'. Both were aware of the nature of the intervention and understood why it was happening.

For the first person, the clear message that came through from their experience was a lack of information from the start of the process. This was compounded by the fact that the assessment took place during the COVID-19 lockdown and was done remotely. This person said that the decision took a long time to make (two or three months) which was anxiety-inducing and stressful for both the person and their relative and there was a 'huge sense of relief' when the wait was over. When asked what, if anything, might reduce the stress, the clear message was the need for more information which would lead to a greater sense of control. Someone else making a decision about their futures felt like an abject loss of control. One of the people we interviewed talked about feeling excluded and unable to reassure their relative so that the period of uncertainty was difficult for both of them. They were not sure whether this exclusion was deliberate and, again, an explanation for this would have helped them both. Both

had a feeling that someone else had the power and was in charge as they had not been involved in the decision-making.

There was a perception that it had been a good outcome for the families but that it would have helped to understand how the decisions were made. Understanding the process of assessment and what informed or influenced decision-making would help them to understand similar situations in the future and would remove any ongoing uncertainty.

For this one person in particular the sense of powerlessness was apparent. They described the anxiety as 'treading on eggshells' in that if you say the wrong thing the BIA can change their mind and take things away from you. They pointed out that if it is stressful and anxiety-inducing for them, then it would be far greater for their relative whose 'life is in the balance'. The person recommended that BIAs remember how powerfully the process can impact people's lives and that, whilst being busy and getting caught up in the job is understandable, the consequences of their decisions can be vast.

When asked about the BIAs professional backgrounds and whether this would make a difference, from a hypothetical position, one spoke from her own professional training (general nursing) and thought that nurses can tend to medicalise things, that occupational therapists would take a holistic approach and that social workers would use a social model which is better than medicalising people's situations.

Finally, in terms of training and education for BIAs they believed the key was recognising the power imbalance, the impact of sharing

information and inclusion, and the anxiety and uncertainty contained within the whole process. Given that this is hard to learn from a textbook trainees should hear from people who have experienced it. The fact that trainees are already professionals means that they are already at an advantage before they even start, so it is about bearing in mind how powerful the decisions can be in somebody's life.

The second person gave a powerful account of an experience that underpinned the ways in which BIAs can address perceived oppressions and respond with authority and influence. Their experience related to a relative who was being deprived of their liberty in a hospital setting, in their view unnecessarily and without any clear lawful remit. They became aware of the team when urgent concerns about their relative's treatment in hospital were raised. They had been prevented from leaving, which did not seem to be reasonable, and there was a need to understand the lawful premise of the decision. They had only become aware of the team because the immediate urgency of the situation had led them to seek help. The situation was described as being 'one of the most concerning of their life' and that the 'learning curve was vertical'. The team responded immediately and their intervention was considered to be critical in what felt like a major crisis.

When asked about the BIA's intervention, this person said that the BIA's objectivity and sense of justice and fairness was clear and well-received. It was described as like going to the hospital with a 'big torch' to illuminate what was going on: to look at facts and records and to clearly

understand what was in the best interests of their relative. The BIAs independent position, legal knowledge and power to effect change made it seem that the 'cavalry had arrived' in terms of the protection and preservation of their relative's needs and rights.

The message was clear that the BIA's capacity to challenge was evident and that there was some comfort in being able to see how powerful they were in addressing what was felt to be an oppressive and disproportionate decision. The professional was clearly an ally for their relative in a situation where people often have no advocate available.

In terms of professional identities an interesting point, which is in keeping with perceptions expressed elsewhere in this report, was that in organisations such as the NHS there are hierarchies where the consultants are seen to be 'at the top'. BIAs who come from nursing backgrounds and are aware of such professional cultures may be inclined to defend this and identify with their colleagues, consequently being less likely to take an objective position or advocate on behalf of the person. Again, this was not about the professional knowledge-base but rather about having the right attitude along with the capacity for challenge and the ability to be autonomous and independent, which can be hard in an organisation with an inherently defensive culture. To a lesser degree there may be the same organisational or cultural pressures for occupational therapists to identify with colleagues (at the expense of the person) but they do have a greater degree of separation. Ultimately, however, it is a matter of individual character and attitude.

Overall, the work of the safeguarding team and the individual BIA was seen as being essential, indeed a 'lifesaver'. The view was that it is essential that they maintain their autonomy and independence from medical decision-makers and retain the power to influence and to safeguard. The interest in the person and the ability to problem-solve quickly and effectively in difficult legal terrain was apparent and there was a demonstrably clear and understandable concern that decisions regarding people's liberty can not be taken lightly. Where knowledge of statute and process is lacking (in this case in a hospital setting) there is a need for professionals who are well-informed to step in quickly to address shortcomings. There is an essential consideration around whose interests are being prioritised: in this person's case the interests of the professionals within the hospital setting and the interests of the individual person were 'chalk and cheese'. The professional who intervened took an objective, rights-based approach and the sense of advocacy on behalf of their relative was powerful.

The overall message in this case was that the intervention by the safeguarding team had been powerful and instrumental and yet they had only been 'stumbled upon' by chance in a desperate situation. There should be greater awareness of this area of work to ensure that people's needs are met and that people are genuinely protected when finding themselves in such situations of vulnerability.

Best Interests Assessors: Focus group themes

At the end of the BIA survey, respondents were invited to participate in focus groups to explore the data further. Overall, the representation was as follows: from 28 participants, 23 (82%) were social workers and 5 (18%) nurses. There were 21 (75%) female participants and 7 (25%) males. In terms of ethnicity, there were 25 (89%) in the White categories, 1 dual heritage (4%) and 2 did not share this information (7%). Individual focus group breakdowns can be found in the Annex. There is no national data to weigh this against.

Motivation

Respondents gave a variety of reasons for undertaking the BIA training. For some social workers it was an expectation of their local authority employer. This has parallels with some AMHPs' positions. Some participants undertook the training reluctantly or stated that they were not fully aware at the time of what the role entailed, but that generally they came to value the role once they had undertaken the training and were more confident. These views align with the data obtained from the BIA surveys where the benefit of the role and understanding of its professional context developed as time progressed.

Others had completed the training because they were interested in finding out more. Some became interested in the role through discussions with other BIAs or observations about the impact of DoLS in practice; they regularly cited the human rights aspect of BIA work and the focus on autonomy and independence. Seeing other BIAs practising and how much they enjoyed or valued the role was also a factor. There was also an element of anti-oppressive practice identified and there were some concerns about the way people had been treated, They saw BIA work as a way of bringing positive change which, again, was consistent with some AMHPs' motivations. These views connect with the literature which suggest that BIAs have a clear view that their role is to safeguard the legal rights of people whose care amounts to a deprivation of liberty:

"I wanted better training on the MCA but I just wanted to work in a role where I felt that maybe I could make a difference in relation to people's human rights" (social work BIA)

For some of the BIAs, training was a progression route to other things such as AMHP training, senior posts or areas of practice they thought would be more interesting or rewarding, such as safeguarding teams or DoLS teams. Some BIAs saw the opportunity for independent practice as part of retirement or more flexible working arrangements that worked for them. Some saw a natural progression from their current role, as

they were already involved in complex decision-making and safeguarding, so a more in-depth knowledge seemed to be essential learning and a way of improving or consolidating their legal literacy. One BIA saw it as a way of reconnecting with the social work role:

"I think it is a big failing in social workers. The fact that as you become a manager you do less of the work that you trained to do. But [...] for 40 years, 30 years of which has been as a manager, I'm now [as a BIA] actually meeting people [...] this is amazing"
(social work BIA)

The Mental Capacity Act was viewed as a progressive piece of legislation which they wanted to utilise in their practice. There was a desire to know more about how legal decisions were being made and a view that the knowledge and skills involved in this type of legal decision making were valued by employers. There were others who were unhappy about the way in which the BIA role was being undertaken and wanted to address that in practice:

"I was working as a mental health nurse in a large General Hospital [and capacity] was quite poorly understood and [...] just the lack of knowledge was quite astounding, myself included [...] And now [...] there are lots of places that it's still really poorly understood [...] but you know back then it was even less so. So that's kind of how I how I got into it"
(nurse BIA)

The independence of the role

A large proportion of BIAs said they valued the independence of the role and this was a strong theme throughout the discussions. The independence of the role was essential in upholding the human rights element of the DoLS, a theme that was frequently repeated. This independence was expressed in several ways. There was a strongly held belief that because DoLS was underpinned by human rights legislation and case law this offered a degree of protection when making decisions. The adherence to a procedure prescribed by law enabled them to resist pressure from managing authorities and their own employers or managers. This was described as very different to the day-to-day care management that was procedural, constrained by budgets and dependent on higher management approval:

"If I need to go and see somebody several times [...] I'm given the autonomy to make that decision. And [...] it just allows you to think outside the box as well [...] the amount of time you actually spend with somebody you have more autonomy over that"
(social work BIA)

"You're still expected [in] very archaic local authorities [to be told] how things should run and people get micromanaged to [within] an inch of their life [...] it's a role that gives you the option to be independent"
(social work BIA)

Some BIAs thought that the role could or should be more independent from local authorities despite its relative level of autonomy:

"There are lots of things that are [problematic] and I strongly believe BIAs should be [more] independent from local authorities"
(social work BIA)

"There's a bit of a culture that you are still expected to fall into line because if you're employed by [the local authority] they want you to toe the line still. I never thought you are 100% independent if you're employed by them"
(social work BIA)

Although many BIAs expressed many positive aspects to the role and wanted to continue working as a BIA, there were expressions of how stressful the role can be and how time pressures can compromise their independence, particularly where they were not full time BIAs.

BIA work enabled the challenge to institutional poor practice and to effect change through the power of setting conditions, making recommendations, limiting the length of the DoLS, determining the person's capacity or questioning whether the deprivation was in the person's best interest. This connects well with the literature that suggests that the BIA and DoLS role is not to detain the individual, but to safeguard the rights of the person whose deprivation of liberty is current or being sought.

The considerations of people's liberty clearly features within the professional practice of both BIAs and AMHPs but it is framed in different ways. The majority of AMHPs understood their role as being a 'legal role' where decisions were made as to whether a person meets the legal criteria for detention in hospital, whereas BIAs viewed their assessments as an 'extension of [their] role' where they are reviewing the care already being given to the person.

BIA work as varied work

Social workers in particular expressed satisfaction that their BIA role enabled them to address difficulties that they had observed in daily practice. The role was different from casework but it still connected in terms of the principles the BIAs wished to uphold. The work was described as interesting and challenging, due to the complexity of the decision making, and there was the belief that the skills and knowledge developed in BIA work also influenced other areas of practice. The work is seen as less routine, even though there is a clear legal structure and process to be followed. The work empowered the practitioner to promote autonomy and independence and the clear legal procedure made it defensible. BIA work was also less focused on financial packages and needs based assessment, risk reduction and was more focused on promoting human rights and autonomy.

"You [...] had to fight tooth and nail with your own organization to get [...] basic needs met, let alone [...] anything that we might consider [to be] lifestyle choice" (social work BIA)

Other benefits of BIA work that differed from care management were the short-term nature of the work. BIAs said that it is boundaried, unlike casework, and it is clear what is expected of them. Consequently, for some BIAs this creates less stress as there is greater clarity about what is expected. This was particularly the case for independent BIAs as there is more control over the flow of work.

BIAs and professional identities

Both BIA and AMHP focus group participants were aware of others' (particularly social workers') perceptions that their practice was influenced by their professional or organisational background which may lead to deference or a lack of ability to challenge within the confines of a hierarchical organisation. Yet there was evidence for BIAs, as well as AMHPs, that nurses chose the BIA role because they valued and wanted the independence that it gave them in their decision making. Sometimes, this was represented as a belief that the new roles gave them a different perspective or that it built on knowledge and skills that they had already acquired. Nurse BIAs made reference to their organisational

background and experience of a 'paternalistic culture' whereby:

"[In hospitals] [...] you don't really stop and think of the situation from the perspective of capacity, you think about it from the perspective of the delivery of a service [and] when you've got these people in an acute hospital and you know that you can do something for them that will alter their circumstances, you lose focus on whether or not they want that done to them" (nurse BIA)

"I trained colleagues across the Trust about things like the need to assess capacity. We in health, I think we're probably still years behind, actually, really believing and living what we know to be the correct way. So when I trained [as a BIA] a lot of what I knew in theory, I could suddenly practice" (nurse BIA)

Overall, differences did not seem as profound within the BIA groups compared to the AMHP ones. This may be due to their own experiences, the nature of the work or it may relate to the fact that the BIA role has not had the same history in terms of it being adapted or inherited from being a social work only role.

Values, rights-based work and advanced practice

All the professionals thought that the role of BIA sat well with their professional values. There was a strong theme that the role was something that enabled them to practice as they should be able to in other areas. They believed they were more independent and autonomous in their decision making and less restricted by their employers or managers. They spoke about the role allowing them to promote human rights and professional values in a way they were otherwise denied:

"Just the idea that it's embedded in people's human rights was what really attracted me to the role" (social work BIA)

Some social workers believed that the BIA role was more closely aligned to the ethics and values of their profession, although there was a widespread belief that in practice different professionals worked in similar ways and that each profession brought something valuable to the role:

"I believe that all the different backgrounds massively influence us and they can bring real benefits [...] and the occupational therapists becoming BIA's [has] made us really think differently about [...] aspects of care and objection" (social work BIA)

"I think other professions just add [...] a different insight and [...] it really benefits our practice" (social work BIA)

Social workers used a range of phrases that suggested that the BIA role flowed naturally from their social work training, practice, and values. They believed that their BIA work was 'real social work':

"I also get a feeling that it was a bit more like the social work that I trained to do [...] just felt a bit more like traditional social work than how frontline social workers [are being] asked to work now" (social work BIA)

"The role fits very well with the core professional values of things like empowerment, respect, dignity, inclusion, and anti-discriminatory approaches" (social work BIA)

This was reflected by some non-social workers who identified their BIA work as enabling them to practice in ways rooted in social work interventions that were, or should be, part of their professional ethos. Promoting autonomy, independence, dignity, human rights, choice, respect, inclusion and empowerment were beliefs and values that were regularly referred to by all the participants. They also talked about BIA work allowing them to use their interpersonal skills to enable the person and their family to have their voice heard, tell their story and to work through a period of challenge and change in their lives.

Maintaining knowledge and skills

There were a lot of similarities within the BIA focus groups in the ways that they updated their training. They attended peer support meetings, regional conferences, specific in-house training events and private training. Some BIAs received specific supervision or mentoring and shadowing was a good learning opportunity, including their being shadowed. There was effective use of the internet, social media and blog sites.

The discussion about future plans focused mainly on whether they would seek to convert to the AMCP role. Consistent with the survey, an estimated 80% to 90% of the sample were definite about moving over to the AMCP role, either because it was an expectation of their employment or they believed that the role would hold the same value for them as the current BIA role. Although most BIAs were expressing the wish to work as an AMCP there was also uncertainty about the Liberty Protection Safeguards which led to doubts about whether they could or would convert to the new role. These anxieties were expressed both by those who were planning to convert and the minority who said they might not do so.

For some it was about practicalities about whether they will be offered the opportunity to convert. The independent BIAs queried if there would be a demand for them under the new regime. There was a similar view from BIAs employed by local authorities who questioned if the same number of AMCPs as BIAs would be required.

There were different views about LPS, the role of the AMCP and uncertainty about what the role will look like. Some were enthusiastic about LPS and believed that the AMCP may be afforded the same status as the AMHP. There was also the belief expressed that AMCP work might be more closely aligned with the work of the community teams which was seen as a good opportunity.

There was trepidation about whether LPS will continue to provide the same safeguards for the person and independence for the AMCP. There were concerns that LPS was 'less interesting' or a diluted version of DoLS and was likely to compromise many of the human rights protections embedded in the current system. Along with this was a belief that the current independent role of the BIA might not be reflected in the AMCP role:

"It feels like some of that role of the BIA that's really important is kind of going by the wayside and we may well just become reviewers of other people's paperwork" (social work BIA)

"I love and I still do like doing mental capacity assessments. I think when they go to LPS that's going to be quite difficult for me, I'm not going to do that part [anymore]" (social work BIA)

Some BIAs believed that the role of the AMCP would be the reviewing of decisions already made by others without the current safeguards of care home visits, time spent with the person and their family assessing capacity and determining best interest. The majority expressed the wish to train as AMCPs but were unsure or unconvinced that the role would maintain its independence and value.

Overall, there was a sense that there was uncertainty as to what the role will look like:

"Nobody really has got a real idea of how it's going to turn out, so there's a discussion, but it's nothing set in stone yet. It's just early days, really" (social work BIA)

"I'm yet to be convinced that LPS as we know it is actually going to be the end result… And there are various conflicts of interest" (social work BIA)

And there were some BIAs who had a sense of pessimism:

"It would be really interesting to see how things pan out in terms of any reforms to the European Convention of Human Rights - where Britain is going to sit in terms […] of promoting human rights because it could go badly" (social work BIA)
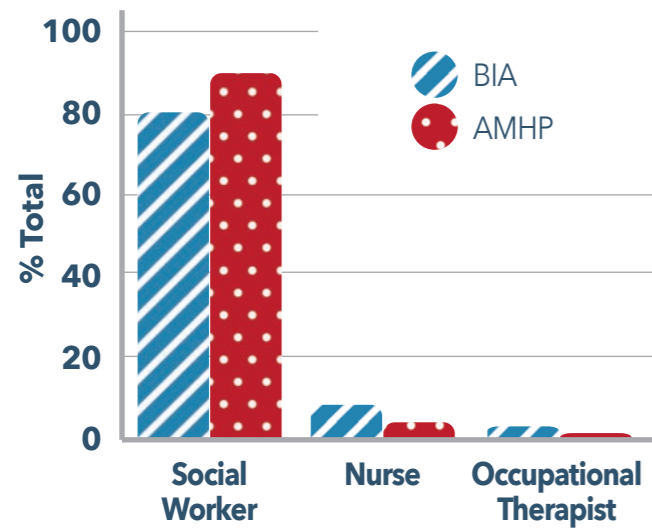
Workstreams 1 and 2: Summary of AMHPs and BIAs

As illustrated below, our representation of social work, nursing and occupational therapy AMHPs was broadly in line with the national weighting.

Demographic comparisons

What is your primary professional background?

Both the AMHP and BIA workforces are predominantly made up of social workers and predominantly employed by local authorities. Fewer BIAs are employed by mental health Trusts and BIAs are more likely than AMHPs to be independently employed. The majority of those who took part in our research were social workers, with slightly more nurses taking up the BIA role than the AMHP role. Occupational therapy BIA and AMHP numbers were very low but this is in

keeping with the national demographic. Many of our respondents and participants said that they had never, or rarely, worked with AMHPs or BIAs who were not social workers. This, too, is in line with what we know about the national demographic and workforce data.
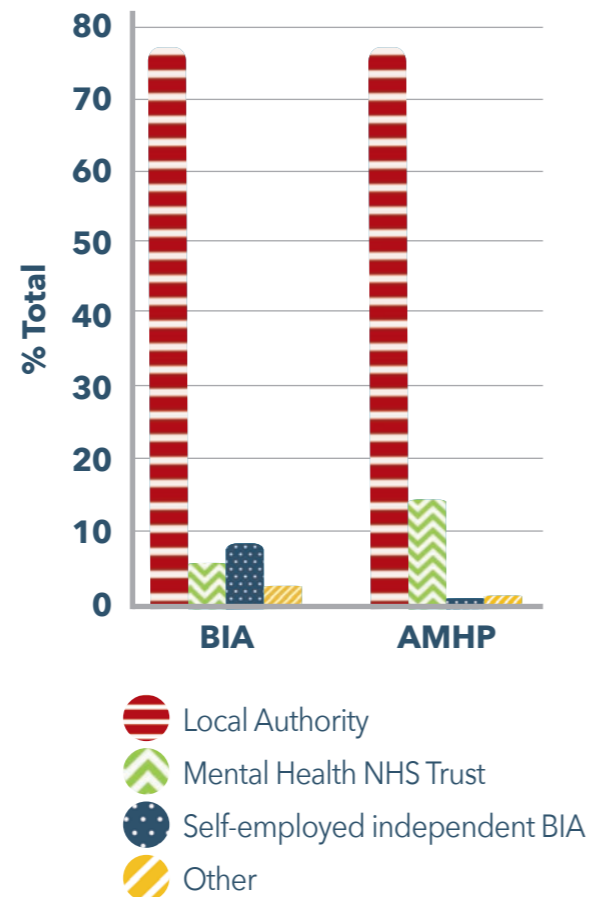
Who is your current employer?
(% responses)

● Local Authority
● Mental Health NHS Trust
● Self-employed independent BIA
● Other

Is working as a BIA/AMHP your primary role?
(% responses)

● Yes ● No
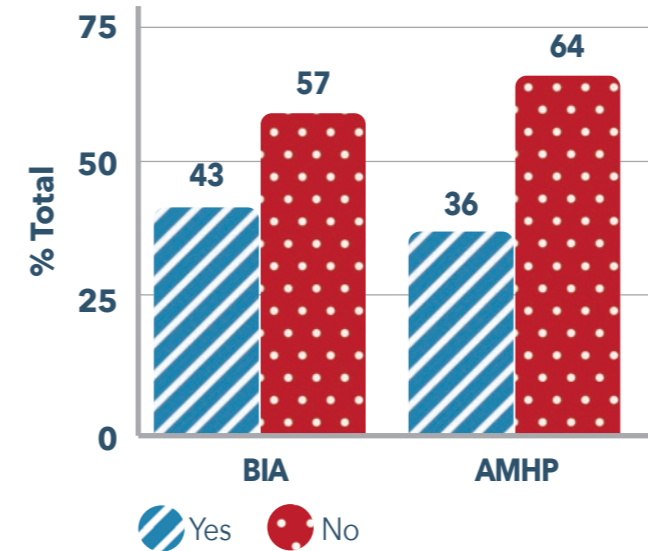
In our survey samples there was a significant number of primary (full-time) AMHPs (36%) and BIA (43%) roles, but the majority in both groups retained a mixed, shared or part-time role. BIAs were slightly more likely to have their role full-time.

Age groups

● BIA ● AMHP
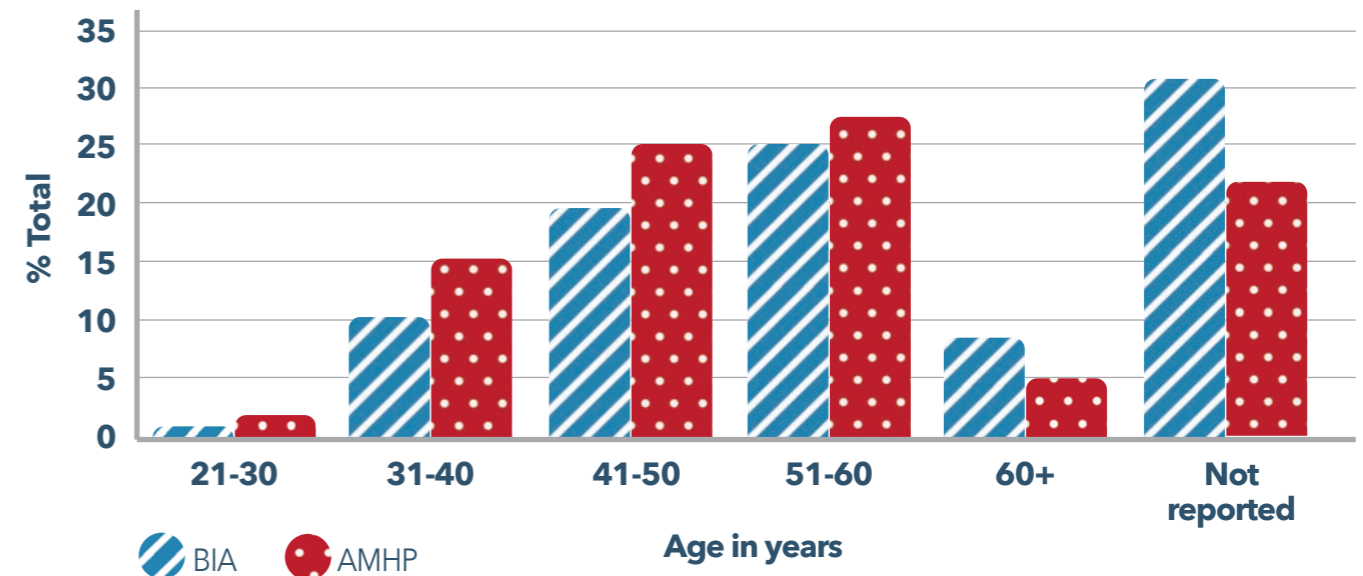
From the respondents who shared the information, AMHPs and BIAs are roughly similar in their age demographics with the clusters falling into line with what we know about AMHPs' ageing workforce. National data is not yet available for BIAs

but, given that there are more BIAs who are over 60 in our sample, it is likely to be at least equivalent. This is against a backdrop of the demand for AMHPs' and BIAs' skills and knowledge growing year on year.

Did the regulated professions make a difference to the AMHP or BIA role?

One of the primary aims of the research was to understand whether professional identities and the way AMHPs and BIAs go about their practice is influenced by their regulated professions. There were some differences but these were not pronounced.

Do you think that being a BIA/AMHP is a:
(% responses)
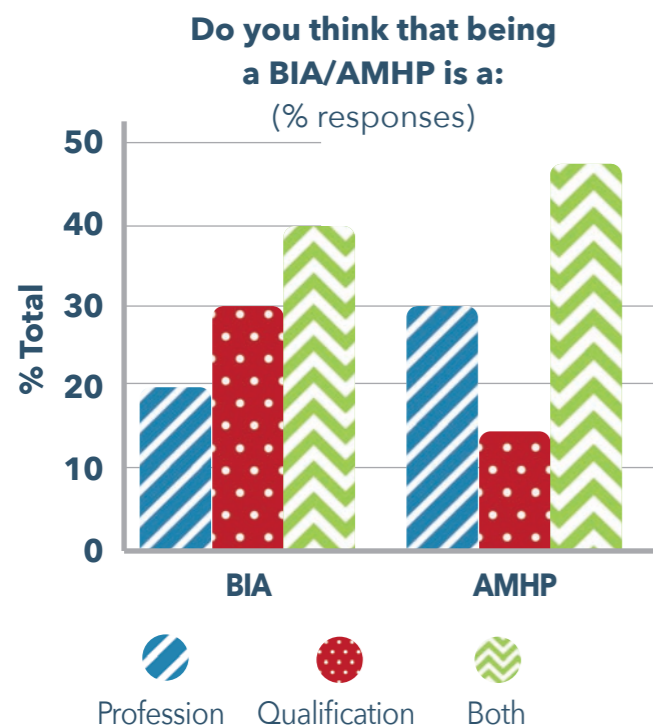
AMHPs were less inclined to see their role as a mere qualification and there were distinct interpretations of the unique professionalism and values-based practice attached to the role. However, both professions, to varying degrees, believed that their specialist work was advanced, relational and values-based and for many it went beyond an extension of their primary qualification with enhanced legal literacy that was creative and nuanced.

For AMHPs and BIAs, there was some speculation from social workers that nurses would default to a 'medical model' approach and be less likely than social workers to use a social perspective. Equally, there was a concern that nurses might be less likely to act with the requisite independence and capacity to challenge where peoples' rights are not being upheld. These ideas were challenged within this research. Despite concerns about nurses' proximity to, and deference within, hierarchical 'health systems' and the ways in which these might hamper their capacity for challenge, there was interesting emerging evidence that an aspiration to challenge hierarchies, or oppressive and poor practice, was of itself a motivating factor for nurses to seek the specialist training in the first instance. Contrary to perceived wisdom, then, some nurses may be attracted to the roles precisely because they are interested in furthering a rights-based agenda through their ability to take an independent stance with an enhanced capacity for challenge.

Throughout the research the perceived professional differences were less stark for BIAs which might be due to the fact that this has never been a social work only role, or it may simply be due to the inherent nature of the role. On the whole it did seem that the BIA world represented a broader church in terms of being inclusive of those professionals who were from a non-social work background. For reasons that remain unclear, BIAs did not highlight the same structural barriers to non-social work professionals coming forward for specialist training as those highlighted by

AMHPs, who attributed this to the separation of the health and social care systems.

What the professions bring to AMHP and BIA practice

Overall the majority of AMHPs and BIAs believed that social work had the greatest influence on the work. Generally, aspects of social justice and advocacy, as well as a high level of legal literacy, were clear indicators of the contribution of social work to both AMHP and BIA work. AMHPs and BIAs seek to challenge discrimination and oppression as an inherent part of their role and both have values compelling them to address injustices and to act in a fair, rights-based way. AMHPs and BIAs aim to work in a way that maximises least restrictive approaches in order to avoid injustice and unnecessary oppressions. The other professions were seen to influence the roles in additional and generally complementary ways: nurses brought medical knowledge and occupational therapists had knowledge of practical and functional interventions.

In terms of shared values, AMHPs seemed to reference their shared, specific value base and values-based practice, regardless of their regulated profession, more frequently than BIAs, where the suggestion is that this is still an emerging feature of the work. Reasons for this were speculative but included different training models, different aspects of peer support and engagement or simply a broader professional spread from the inception of the role.

For AMHPs, in particular, problems associated with perceived hierarchies appeared time and again throughout the research, ultimately leading to a hypothesis that identities are more aligned with organisational rather than professional ones. Where they had the experience of working with different professions, AMHPs and BIAs from any of the regulated professions were seen to do an effective job if they have sufficient distance, autonomy and independence from 'health systems' and hierarchies and an attitude and level of assertiveness that promotes challenge. A small number of nurse BIAs identified that there were different approaches within hospital settings and that these did not always recognise people's choices or promote self-determination. Here, there was evidence that they too chose their specialist role because they valued and wanted the independence that it gave them in their decision making. One person with lived experience of the BIA role particularly valued the social work BIAs' independence and ability to effectively challenge and redress problematic decisions that had been made in a hospital setting.

For both social work and nurse AMHPs there were a small number of observations that social workers have a better working knowledge of local authority funded support packages and, either because of limited knowledge or access, nurses have less social care experience. This was not a theme apparent within the BIA workforce.

Support

For AMHPs there was a shared, consistent idea that working alongside each other and deriving support from peers and colleagues is in many respects essential. Peer support was the primary means of support for AMHPs and the implications from the qualitative research were that this would remain the case, even where dedicated supervision is available. This was due to the stress and uncertainty attached to the work on a daily basis. BIAs did not seem to rely as much on peer support, but they did hold training in far higher regard than AMHPs. This may be due to their more frequently changing legislative landscape.

In terms of professional identities, a by-product of the culture of AMHPs' peer support is that a 'cross-fertilisation' (in the words of a social worker AMHP) occurs in relation to the core AMHP professional imperatives and the ways in which non-social work AMHPs assimilate these values. This cross-fertilisation will, however, need nurturing.

Both AMHPs and BIAs have been profoundly affected by the COVID-19 restrictions, with AMHPs highlighting the ways in which it has removed a valuable source of peer supervision which had hitherto mitigated against high or intolerable levels of stress and burnout. For both groups, however, there has been the wider impacts of increasing referrals and increased workload alongside reduced opportunities to maintain wellbeing, increased personal isolation and reduced social outlets. The legacy of COVID-19 remains to play out fully but

certainly, the increasingly isolated ways of work are of concern, particularly for AMHPs who value peer support and peer supervision so greatly.
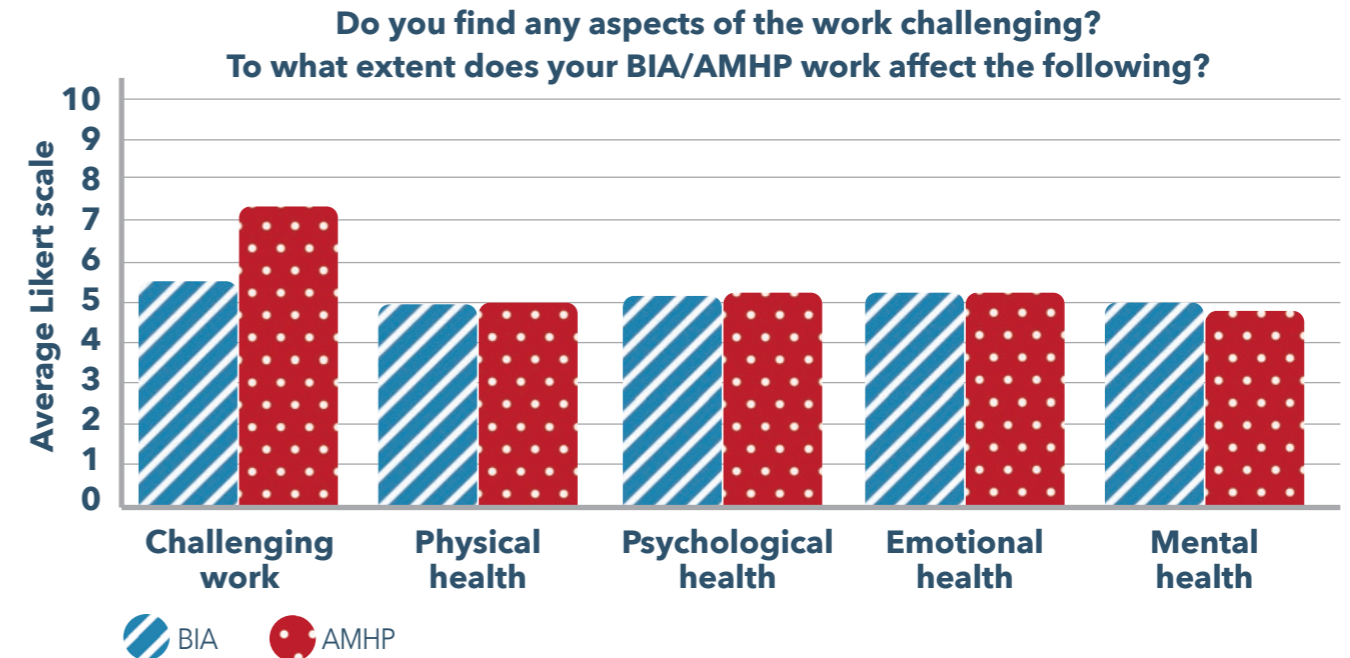
Rewards of the work

Similarities between the AMHP and BIA roles include the ways in which the short-term and focused nature of the work is a satisfying alternative to the typical case-management model of social work that prevails in local authority adult social work teams. Both AMHPs and BIAs expressed levels of professional fulfilment with the responsibilities and duties of their respective roles. Assessments under the Mental Health Act and assessments within the DoLS process felt 'satisfying' for both groups of professionals as the end result was one which placed the person's needs at the centre of decision making. There was a very clear focus in terms of a legal process where safeguarding the person's rights and wellbeing held a central place within practice and, therefore, aligned with their professional values, knowledge, and training.

Both AMHPs and BIAs acknowledged the legal function of their role and that the outcomes of their work can result in people being lawfully deprived of their liberty. Values of human rights, particularly in relation to liberty and security of the person (Art 5, Human Rights Act 1998), underpin both roles' considerations and function. It was interesting to note that most BIAs were clearly of the view that their primary role was to safeguard the person's right to liberty, before reflecting upon whether they were detaining the

person or not. A difference between the BIA and the AMHP is that the AMHP will act as the applicant for a detention, whereas the BIA may make a recommendation to the Supervisory Body that the person is being deprived of their liberty with that deprivation being in the person's best interests. As mentioned previously, even though the BIA does not effectively detain the person (whereas the AMHP does) both groups of professionals view their role within the context of seeking least restrictive options and principles of necessity and proportionality.

In line with these legal functions, both AMHPs and BIAs were keen to ensure that relatives and carers had their rights explained to them and were supported throughout the process of the DoLS or Mental Health Act assessment. AMHPs and BIAs seem to strive to manage the challenges and complexities of supporting family members and carers and both groups, irrespective of professional background, acknowledge the importance of explaining legal processes and outcomes to those interested in the health and welfare of the person being assessed.

Challenges of the work

Do you find any aspects of the work challenging? To what extent does your BIA/AMHP work affect the following?

AMHPs and BIAs seem to experience very similar impacts on their health and wellbeing arising out of the challenges they experience. The main difference in this area was that AMHPs report finding

their role more challenging than BIAs experience which is likely due to workload pressures and a lack of resources which is beyond their control.

There were clear frustrations with the NHS and 'health systems', particularly from social workers who locate themselves physically or figuratively within local authorities. One strong, clear, consistent and persistent message was that the NHS and 'health systems' are responsible for the provision - or failure to provide - of resources and support networks which fundamentally enable or prevent AMHPs from doing their work. This is one of the main sources of stress, anguish, guilt and burnout - they are ultimately unable to meet people's needs and complete their work in a way which aligns with their core professional principles. Given the aspirations towards rights-based, least restrictive outcomes based on empowering and involving people they are continually thwarted in their work. People are assessed repeatedly and, even where hospital beds are finally found, these are still often seen as being inadequate or un-therapeutic.

For AMHPs, in particular, the frustration attached to seeing the person experience or endure repeated assessments while no bed can be found was conveyed. Some AMHPs indicated that the relentlessness of these types of problems was a reason why their AMHP career was time limited. Both workstreams spoke of being rushed, feeling compromised and having to complete work in their own time.

While some BIAs and AMHPs found their specialist roles better for their life-work balance, a significant number are finding it increasingly difficult to carry out the work in a professional and person-centred way due to intolerable workloads. Both sets of focus groups painted a clear

picture of a system and a workforce that is frequently overwhelmed. Where there are no beds, people are being assessed 'over and over and over again'. These repeat assessments are time-consuming but, more fundamentally, they represent a failure to meet someone's needs where they are left waiting in inadequate, unsuitable and sometimes unsafe environments.

For a number of participants, particularly AMHPs, there were a range of barriers to being able to continue to undertake the work. The work pressures highlighted above, the long hours and having to work in their own time means it is not possible to fit this around other responsibilities. The impact on family commitments and caring roles was for some AMHPs the reason to not be able to continue with their work. This is often understood to affect women in terms of traditional labour roles, but our research indicated that this affected male AMHPs to the same degree. This did not seem to be such an explicit difficulty with the BIAs who took part.

Allied to this, time pressures were a challenge with almost all AMHPs and some BIAs describing feeling rushed and without the ability to slow things down. It is unclear, and perhaps worthy of further study, as to whether it made a difference whether the AMHP or BIA had a full time or mixed role and whether or not service structure makes a difference. Full time workers described the ways in which the workload pressures become such that they are unable to say no to further work leading to their feeling compromised in terms of the depth and quality of the work.

Mixed role or part time workers described clear challenges in terms of their inability to fit everything in, as well as the fact that their specialism is often not recognised as being a legitimate part of the work. This leads to an increased level of stress and anxiety and a perception that it is difficult to manage the competing roles.

Empowerment and involvement: working with people

AMHPs and BIAs both aspire to work in a way that is empowering and which maximises self-determination, but both groups reported significant obstacles to this. These obstacles were usually resource-driven and a clear and consistent experience for AMHPs, BIAs and those who have experienced their interventions was the lack of time to carry out good quality assessments leading to the best outcomes.

Both groups, but AMHPs in particular, regretted that they did not have enough time to spend with the people they were assessing and to embed the statutory Empowerment and Involvement principle. Some spoke of their aspirations to share the decision making with people, but they often felt rushed and expressed feelings of guilt that they were consequently not able to maximise people's self-determination by supporting choices around alternatives to admission. AMHPs valued the advocacy attached to the role and yet people did not identify with this seeing AMHPs as merely being part of a team. Guilt was also expressed where

AMHPs, in particular, acknowledged that hospital wards were often non-therapeutic and not conducive to recovery.

Independence, autonomy, power and the capacity to challenge

AMHPs and BIAs both frequently referenced the independence of their respective roles. Arguably, AMHPs valued the elements of independent decision-making to a greater degree which is likely to be due to their statutory position of independence. BIAs appeared to contextualise independence as working alone, within the assessment process, as they will rarely have contact with the Mental Health Assessor during the DoLS assessment process. The fact that BIAs operate alone, rather than arriving as part of a team, did seem to make them more visible and give a greater clarity to their role for people with lived experience of their interventions. There was evidence, however, that as with AMHPs, many nurse BIAs chose their specialist role because they valued and wanted the independence that it gave them in their decision making.

A clear and consistent message for both groups was around power. AMHPs appreciated the power attached to the role as this enables them to challenge, advocate and tackle aspects of discrimination within mental health services. BIAs had a similar aspiration and talked about the lack of power that they had to effect change within hospitals and care home settings.

Both AMHPs and BIAs reflected on their apparent lack of visibility and the ways in which this impacted on their influence. For BIAs, the frustration was less that the role was misunderstood and more that the law was misunderstood and a lot of time was taken up explaining this to other people. Both AMHPs and BIAs saw challenges as arising from dealing with medical professionals who often have a very different interpretation of the agenda to them.

Stress, burnout, support and retention

We heard many comments about the positive aspects of the roles, the rewards associated with autonomous work and the opportunity to make a positive difference to people's lives. However, the emotional labour attached to both roles came through clearly, particularly where AMHPs and BIAs engaged with people experiencing significant traumas or illnesses. The difficulties associated with the work such as unsustainable workloads and the lack of resources was clear. At times, within the focus groups, the stress and anguish was palpable and visceral.

There have been longstanding difficulties with AMHPs' levels of stress, ill-health and burnout and their impact upon recruitment and retention. Indeed, this is understood to be a primary rationale for broadening the role to professions other than social work. For AMHPs in particular peer support is essential, particularly AMHPs, yet remote working due to

COVID-19 has undermined this. To exacerbate this, a significant number of AMHPs and BIAs said that they did not receive dedicated supervision.

The National Workforce Plan for AMHPs (DHSC, 2019) has recognised some of these problems, summed up as the need to:

Support the independence of AMHP decision making, while ensuring access to individual, peer and professional support to explore working practices in a safe manner, including timely de-brief sessions (p.33)

Further, it recommends that 'AMHP supervision should be viewed as the cornerstone of quality AMHP practice' (p.33). Standard 4 of this plan is entitled 'AMHPs' personal, professional, physical and psychological safety' and here there is a recommendation that services 'ensure that AMHPs' safety and well-being is at the forefront of operational considerations' (p.33). Reference is also made within this report to ADASS' policy recommendations that AMHPs' morale, workload and work-stress issues should be monitored with partners at a strategic level, for example, with health and wellbeing boards (ADASS, 2018).

There is as yet no equivalent national plan for BIAs.

Training, education and knowledge development

Explaining relevant legislation to people who use services and carers was an essential element of both roles but BIAs, in particular, identified it as a time-consuming task that was not always well recognised. Some BIA respondents were also of the opinion that more protected professional development time from their employer was needed in order to undertake the work effectively. This relates to the perceived relatively low status BIAs thought that their role had and the opinion of many BIAs that their training was too short to thoroughly prepare them.

An interesting area of difference between AMHPs and BIAs is in respect of training. BIAs found training to be a far more valuable support strategy than AMHPs. Both groups described their training as being strongly legalistic and whereas AMHPs saw this as something of a weakness, BIAs valued it. This may reflect the different legal landscapes where for BIAs there are more frequent changes and updates.

A further clear difference in relation to education and training was found in BIAs overall belief that qualifying BIA training does not come close to the quality and depth of AMHP training. Most BIA courses consist of one module delivered over a matter of days compared to AMHP training being over a period of months and containing a practice placement. Although both AMHPs and BIAs have a thirst to be fully equipped with the required skills, knowledge and values to

undertake their role, BIAs believed that a few days' training, albeit for most interesting and enjoyable, did not always equip them to be ready for BIA practice. Some recognised that the training has not kept pace with the developing case law and complexity. Parity in terms of training may well also help with the perception of lower status amongst some BIAs in comparison with AMHPs.

In terms of post-qualifying refresher training, while many enjoyed and benefited from it, there was a belief that this needed to cover more than just law and process with a need also for reflective learning and to fill gaps in specific areas, including communication, trauma and ways in which AMHPs and BIAs tolerate the emotional labour inherent within their roles. In relation to the AMHP literature this is not a new finding: education and training methods have long been seen as being functional and legalistic at the expense of critical reflection and the therapeutic relationship which has a clear impact upon recruitment, retention, health and wellbeing.

People with lived experience of the roles

The views of people with lived experience of Mental Health Act assessments and the AMHP role were aligned to the views of AMHPs in many ways. Both spoke of the importance of good communication, giving someone time and hearing their narrative. Both viewed hospitals as often not therapeutic, conducive to recovery or,

in fact, often likely to re-traumatise the person. People were aware of AMHPs' workloads and the way in which this limited the opportunity to hear their story or to involve them adequately in discussions. This was a matter of regret for those who believe that knowing the person, their history, and understanding who they are is important. Some people spoke of stigmatising attitudes, discriminatory language and organisational prejudices within mental health services – another point mirrored by AMHPs. People also talked about the lack of choice around resources, community support and, in particular, about the impact of being placed in out of area beds.

Perhaps of greatest interest is the perception that AMHPs disappear into the background, along with their role. People generally did not know what an AMHP was and, where they did, this knowledge did not appear to have been gleaned from a Mental Health Act assessment. Several did not know that an AMHP had been present in the assessment, despite their essential role as decision-maker and applicant. Albeit in a different context this mirrors AMHPs' own concerns about their invisibility, a concern shared by BIAs also. Most people stressed the feeling of powerlessness when subject to Mental Health Act and capacity assessments whilst only two people spoke about AMHPs' ability or aspiration to act as an ally and to use this power for good.

Generally, people talked about not being included in the decision-making and that discussions often happened away from

them. This lacks transparency and at its worst leads to a sense of being 'ambushed'. Many people wanted to have more information, and some suggested that a debrief would be helpful.

In terms of professional identities, people tended to similarly conflate nurses with the culture of medical and clinical organisational settings and doctors. People had mixed views on the AMHPs' professional background, with some expressing a preference for social workers (for reasons of a 'social model' alternative to clinical approaches as well as knowledge of community resources). For others, however, the message was generally consistent with an idea that they share the same training, the professional background has no effect, they all do the same job and 'it doesn't matter who drives the bus as long as I get there'.

Nearest Relatives fed back similar themes including the importance of communication, seeing the human side of the work and not just taking a legalistic approach. Information sharing was a key theme and they also thought a debrief would be valuable.

People with lived experience of capacity assessments and people with relatives who had received interventions from BIAs also spoke of the need for a greater level of information to explain what was happening. All were aware of the power attached to the role, with mixed views on whether this was oppressive or used to good effect to achieve a fairer outcome and reduce oppressive practice. There were mixed views around professional

identities with some expressing a preference for a social approach that would not medicalise situations unnecessarily.

Overall, however, for people with lived experience of both AMHPs and BIAs their perceptions have aligned. Good practice is found where the AMHP or BIA is enabled to act independently, advocate soundly, address injustices and oppressions, and have a role that has the power, authority and, crucially, the resources to bring about change.

Dual specialisms

From those who were both AMHPs and BIAs there was overwhelming positivity and recognition that this dual specialism has benefits. Understanding the interface between the Mental Health Act and the Mental Capacity Act improves their understanding of outcomes and it provides a fuller legislative picture. The 'grey area' between the Mental Health Act and Mental Capacity Act has been acknowledged in practice and as part of legislative reforms (Department of Health and Social Care, 2021) and the hope is that people will be supported to achieve outcomes that are no more restrictive than they need to be.

AMHPs and BIAs: Looking to the future

AMHPs and legislative reforms

As a concluding point to this report, it is important to acknowledge the planned reforms in respect of both workstreams. For AMHPs, the government's current White Paper consultation concerning the Mental Health Act reforms (DHSC, 2019) is ostensibly based on a premise of increasing choice and reducing compulsion. It indicates that the new guiding principles will help to redress the balance of power between the person and the mental health professionals thereby improving the person's experience. These new guiding principles are planned to be:

- Choice and autonomy: understood to replace the Empowerment and Involvement principle, this focuses on ensuring people's views and choices are respected and represented, for example, through Advance Choice Documents (prior to admission) and Care and Treatment Plans (throughout admission)

- Least restriction: retains the principles discussed throughout this report in ensuring the Act's powers are used in the least restrictive way

- Therapeutic benefit: aims to ensure that inpatients are supported to get better, so they can be discharged from hospital as soon as possible. An aim is to consider whether, and if so how,

detention and interventions provided under the Act are or would be beneficial to a person's health and recovery

- The person as an individual: aims to ensure that people are viewed and treated as individuals

There is a strong focus on the person's inpatient stay and their right to choose or refuse treatment. It is helpful that the importance of a person's choice is recognised, however, a concern for AMHPs may be that this choice is one that appears to be focused on the point at which a person has already been detained and it appears to pertain only to choices around medication.

Given AMHPs' focus on maximising self-determination and, where possible, shared decision-making, there could be an equally explicit focus on choice at the point of the assessment rather than after hospital admission. This could make use of AMHPs' skills and support their imperative to explore alternatives to admission. It may also serve to broaden the scope from the apparent clinically and medically oriented position. Without an explicit emphasis on alternatives to admission, the principle of least restriction (as it is now) continues to be one that is not achievable and AMHPs are likely to endure the same difficulties.

Choice could extend to whether a person needed to be in hospital at all, and if so which hospital, or it could be a choice that

incorporated adequate support in a crisis (including crisis houses) as a meaningful alternative. In this way, AMHPs would be less likely to detain people unnecessarily (where hospital is the only option) in the way that the literature and our research has highlighted.

One of the ways that people can specify their choices is through the introduction of statutory Advance Choice Documents (ACDs) which will:

'enable people to set out in advance the care and treatment they would prefer, and any treatments they wish to refuse, in the event they are detained under the Act'

The proposal is that ACDs should draw on an individual's expertise in managing their own mental health, but the White Paper indicates that where possible they should be written with support and guidance from an individual's clinician and other trusted health professionals. It is unclear as to whether this involves the role of the mental health social worker and, generally, the language is one that lacks a social perspective. Further, if a person's ACD is indeed about their choice of treatment in hospital, it is unlikely to inform or influence choice at the point of the Mental Health Act assessment.

A more critical reading of the White Paper therefore suggests that the Mental Health Act assessment, and with it AMHPs' visibility, remit and key role as applicant/decision-maker, remains absent. It is hoped that there will be a greater emphasis on autonomy and choice prior

to a hospital admission and that discussions beyond treatment in a hospital setting will be facilitated. Without this, we retain a Mental Health Act which is focused on routes into hospital rather than seeking alternatives to admission or even avoiding a detention in hospital altogether. It compounds an already medicalised view of mental ill health.

Findings here strongly endorse AMHPs' and people with lived experience's hope for mental health services to be trauma informed and to work within a broader social perspective. Unless autonomy and choice is extended to the assessment and it incorporates choices other than treatment in hospital, AMHPs may find it even harder to embed a social perspective with a reinforced traditional psychiatric approach. Certainly, it becomes more difficult to support people's self-determination and for AMHPs to work with the person to find creative alternatives to hospitals if this continues, following decades of research, to be an area of need.

BIAs and legislative reforms

In March 2014, the House of Lords, in their post-legislative review of the Mental Capacity Act (2005), found that DoLS 'were not fit for purpose' and recommended replacing it with a simpler system. Days later, the Supreme Court judgements P v Cheshire West and Chester Council and P v Surrey County Council (known as 'Cheshire West') gave a significantly wider definition of a deprivation of liberty than that which had

been previously understood[9]. Because this judgement resulted in significantly more people being deemed to be deprived of their liberty, local authorities faced tremendous pressure as Supervisory Bodies in arranging the assessments and making authorisations. These and other factors came together to influence the introduction of the new Liberty Protection Safeguards (LPS) to replace DoLS. The future of the role of the BIA is now time-limited, with the anticipated inception of the LPS and Approved Mental Capacity Professional (AMCP) from April 2022.

BIAs in our study had some concerns about what they perceived to be a dilution of what had always been an independent role in challenging safeguarding issues in hospitals and care homes, and advocating for people who are likely to experience powerful care regimes. The LPS has been presented as a welcome and less bureaucratic process which seeks, even more than is currently the case, to place the person at the centre of best interests decision making, further reinforcing and aligning practice with the principles of the Mental Capacity Act 2005. Even though the LPS is said to make the process more efficient, widening the scope of eligibility for an authorised deprivation of liberty combined with AMCPs only being required to approve

authorisations in specific cases is likely to challenge the scrutiny and oversight of authorisations that BIAs have taken pride in being an essential part of.

As LPS will be extended to 16 and 17 year olds and to domestic settings and, as it creates new roles for CCGs and Trusts in authorising arrangements alongside local authorities, there are many new opportunities for existing and new BIAs. A large number of BIAs are currently independent and not directly employed by local authorities but are commissioned by them. At present, LPS will not exclude AMCPs from also being independent (Bond Solon, 2021).[10]

What clearly comes across from the findings in this research is the value of having a range of professionals acting as BIAs. The latest Government impact assessment on the LPS (December 2020)[11] makes no reference to the funding of nurses to receive training on the LPS, which presents concerns as to whether there will be sufficient numbers of AMCPs in post for when LPS is fully implemented. In relation to training to be an AMCP, early suggestions indicate that BIAs will be able to 'convert' to the role by completing a conversion course to bring them up to speed with the new law and anticipated regulations and Code of Practice. Higher Education Institutions (HEIs) will continue

to provide qualifying training, with many of them already making plans for what this will involve. The HEIs will work in partnership with the local authorities and NHS Trusts to implement this and meet the demand for those who will require training and regular law refreshers.

A difference, noted in the findings here, in how AMHPs and BIAs view their respective roles is seen in AMHPs often viewing their role as separate to their professional background (i.e., social worker or nurse) with BIAs viewing their role as an 'extension' of their professional role. Social workers and nurses in particular are often comfortable in challenging practice and advocating for people who are made vulnerable by their circumstances. The independence of the BIA role from that of the Managing Authorities who currently request DoLS authorisations could be compromised if AMCPs are not involved in the new LPS pre-authorisation reviews.

Uncertainty, and some anxiety, is felt amongst professionals as to what the implications of the move from DoLS to LPS will involve and what this will ultimately look like in practice, but it is encouraging that many BIAs view their role as being that of an advocate and guiding-light to support people and carers through the complex, challenging and, often, distressing process of a person being deprived of their liberty. Although significant change is certain, the strong values and sound professional practice amongst the BIA workforce will remain and hopefully underpin the AMCP role.

9 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/ attachment_data/file/956863/Impact-assessment-of-the-MCAA-final.pdf

10 https://www.bondsolon.com/public-an-update-on-the-liberty-protection-safeguards/

11 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attac hment_data/file/956863/Impact-assessment-of-the-MCAA-final.pdf

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Annex

Focus group participant profiles

Overall AMHP focus group profiles	
Professional background	19 social workers 2 nurses
Gender	10 female 11 male
Ethnicity	13 White British 3 not disclosed 2 White Irish 1 Black British 1 Euro British/ Asian 1 White/Other

AMHP Focus Group 1	
Professional background	4 social workers 1 nurse
Gender	3 female 2 male
Ethnicity	3 White British 2 not disclosed

AMHP Focus Group 2	
Professional background	7 social workers
Gender	3 female 4 male
Ethnicity	5 White British 1 White Irish 1 Not disclosed

AMHP Focus Group 3	
Professional background	4 social workers 1 nurse
Gender	2 female 3 male
Ethnicity	2 White British 1 Black British 1 Euro British/ Asian 1 White/Other

AMHP Focus Group 4	
Professional background	4 social workers
Gender	2 female 2 male
Ethnicity	3 White British 1 White Irish

Overall BIA focus group profiles

Professional background	23 social workers 5 nurses
Gender	21 female 7 male
Ethnicity	23 White British 2 not disclosed 1 Mixed White/ Black Caribbean 1 White Irish 1 White Other

BIA Focus Group 1

Professional background	5 social workers 3 nurses
Gender	4 female 4 male
Ethnicity	5 White British 1 Mixed White/ Black Carribbean 1 White Irish

BIA Focus Group 2

Professional background	6 social workers 2 nurses
Gender	5 female 3 male
Ethnicity	8 White British

BIA Focus Group 3

Professional background	6 social workers
Gender	6 female
Ethnicity	5 White British 1 not disclosed

BIA Focus Group 4

Professional background	6 social workers
Gender	6 female
Ethnicity	5 White British 1 White/Other