

## **Book Chapter –Pre Published copy**

### **New and Emerging Roles**

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#### Introduction

This chapter explores some of the ways that traditional role boundaries are changing and how this impacts on service delivery. To illustrate some of the challenges that change creates we focus on two contrasting roles that of the Approved Mental Health Professional (AMHP) and the Specialist Paramedic (SPM) to illustrate the way in which roles are changing and expanding as in the case of the SP and, in relation to AMHP, how a role previously undertaken by one professional can now be undertaken by a much wider range of professionals. The chapter is written by professionals and academics who have witnessed and are now involved in the resulting changes to service delivery. The first section is written by GS, a specialist paramedic who is involved in educating these professionals for their expanding role. The second section is written by KS a social worker who is now an AMHP and JT, also a social worker who used to specialise in mental health work and more recently has been involved in teaching and researching IP learning and working.

#### Specialist Paramedic

Emergency ambulance services are a critical component of the United Kingdom's urgent and emergency healthcare system. Ambulance personnel deal daily with an extraordinary range of conditions and severity, ranging from mild fevers to massive multiple-traumas. The work they do is challenging, emotional, at times dangerous, and often highly rewarding. The ambulance service response encompasses the primary stages of the emergency care pathway including responding to emergency 999 calls; dispatch of personnel to the scene of an illness or trauma; and triage, treatment and transport by ambulance or air-ambulance. In 2009-10, 8.2 million emergency '999' calls were responded to by ambulance crews across England and Wales (NAO 2011, WAS, 2011). The speed of response and quality of care are critical factors to the ultimate outcome (Bradley, 2005, NAO, 2011). The service is

increasingly recognised as having a wider role, as a gateway to other NHS services and ensuring that service users can access the care they need, closer to their home (NAO, 2011).

The SPM, sometimes referred to as the Emergency Care Practitioner, is a new initiative that is focused on utilising the existing knowledge and experience of emergency healthcare professionals and expanding their expertise and scope of practice (MA, 2004). At this time, there is some confusion of titles for this role; 'specialist paramedic' is the term used in the NHS Allied Health Professions Career Framework and is considered the correct description by their professional body, the College of Paramedics, as it provides greater clarity for the public as to which profession is providing treatment (Bradley, 2011). 'Specialist paramedic' is also preferred by the UK statutory regulator, the Health and Care Professions Council (HCPC), as it uses a designation containing the legally protected professional title.

The SPM role builds upon the primary role of the paramedic who is the registered healthcare professional and senior clinician on an ambulance. Paramedics are educated to degree or diploma level undertaking placements as part of their training primarily with the Ambulance Service; but to foster greater interprofessional understanding also include areas such as Emergency Departments (ED), children's ED, operating departments and central delivery suites. The White Paper 'Taking Healthcare to the Patient' (Bradley, 2005) recommended that paramedic education should have greater commonality with other health professionals with higher education, rather than the ambulance service providing the training. It also recommended that their career pathways should be integrated within the wider NHS, so in addition to their primary qualification SPMs must complete an additional degree level programme with a minimum of 400 hours designated theory learning, and 1000 hours learning in appropriate placements such as Minor Injury Units, NHS Walk-in-Centres and Primary Care locations (Skills for Health, 2007). Large proportions of existing educational programmes focus on individual disciplines and are often aimed at those working in specific health care environments. The SPM programme transcends these boundaries taking recruits from nursing and the allied health professions and aims to prepare individuals to work in a range of settings in hospital and in the community,

where people present with emergency or unscheduled care needs. However, the role mainly focuses on acute clinical assessment, physical examination, diagnosis and treatment of people who call 999 with a range of urgent and unscheduled care needs. In September 2009 there were over 720 SPMs in England, over 95% of whom are paramedics registered with the HCPC (Bradley, 2011) indicating that only 5% are likely to come from a nursing background.

The focus of the SPM role is to enhance people's experience through their emergency care episode and to provide care that is service user-focused rather than system-focused. SPMs are trained to make autonomous decisions based on sound clinical assessment and judgement and to complete episodes of care in a range of settings, when it is safe and appropriate to do so and to arrange appropriate referrals when it is not. They will be sent to emergencies as a single responder and depending on the nature of the emergency call, may be supported by an ambulance crew. SPMs form part of the flexible response to 999 calls. The majority of these calls are for a wide range of urgent and unscheduled medical, traumatic, health and social care (including mental-health care) conditions with only approximately 10% of calls for life-threatening emergency conditions (Bradley, 2005). Traditionally, around 70-77% of calls result in admission to EDs, however when SPMs are utilised, the number is reduced to 45-50% (Mason et al, 2007, Woollard, 2007). These figures support previous research identifying that up to 50% of service users would be better managed in an alternative way (Bradley, 2005). These statistics have been the main driver for development of this new role; along with society's expectation that people with emergency and urgent needs receive more timely care in the most appropriate location for their clinical or social care need, with fewer handovers to other care professionals, reduced use of the ambulance service, ED attendance and hospital admission as the case study that follows explores.

#### Case Study

Mary is a 76 year old retired woman who lives with Rosie, her cat, in a house she has occupied since marrying her husband, Rob, 52 years ago, Rob died last year and Mary has been managing to live on her own with the support of her daughter 'popping-in' occasionally to visit.

Mary has a long-term medical problem; osteo-arthritis of the knees and wrists and is under the care of her GP. She is quite stoical about her condition and puts problems with pain and balance and occasionally falling, down to 'getting old'. These symptoms do affect her mobility and on bad days Mary just minimises her movements around her house. Mary doesn't like to worry her daughter too much because she thinks she has "problems of her own". Recently Mary has suffered a fall in her bathroom when she over-balanced picking up a towel from the floor. She sustained a wound to her forehead and was unable to get herself up from the floor or to get to the phone to seek assistance. She spent the night on the bathroom floor and was able to keep warm by pulling a pile of laundry, from a low shelf, onto herself. In the morning an unanswered phone call from her daughter, resulted in a 999 call to the ambulance service. A SPM in a rapid-response car was dispatched to her assistance.

### QUESTIONS

1. What fears do you think Mary might have?
2. How might John respond to those concerns?
3. What options might be available to John in managing Mary's condition?

Falls are a significant cause of disability and a major health issue for older people (DH 2001), with over 400,000 attending the ED as a result and accounting for 10% of calls (Halter et al, 2004).

In our case study, a traditional ambulance response to Mary's falls would usually result in transfer to the ED for wound assessment and closure; probably resulting in admission for observation and an assessment of her ability to cope at home. Sending a SPM to Mary's assistance provides an increased range of treatment options and service user choice.

### Case Study (Continued)

Upon arrival at the house, John, the SPM, introduces himself and commences an assessment of Mary's injuries and health status. The initial examination will focus on establishing whether she has any life-threatening/time critical features and obtaining a focused history of what happened.

Having established that Mary has a head wound, John completes a full neurological assessment to help inform the diagnostic reasoning and clinical decision making process.

Mary is very worried about going into hospital. She is concerned about who will look after her cat; about being able to return to her own home and about an increase in dependence and disability.

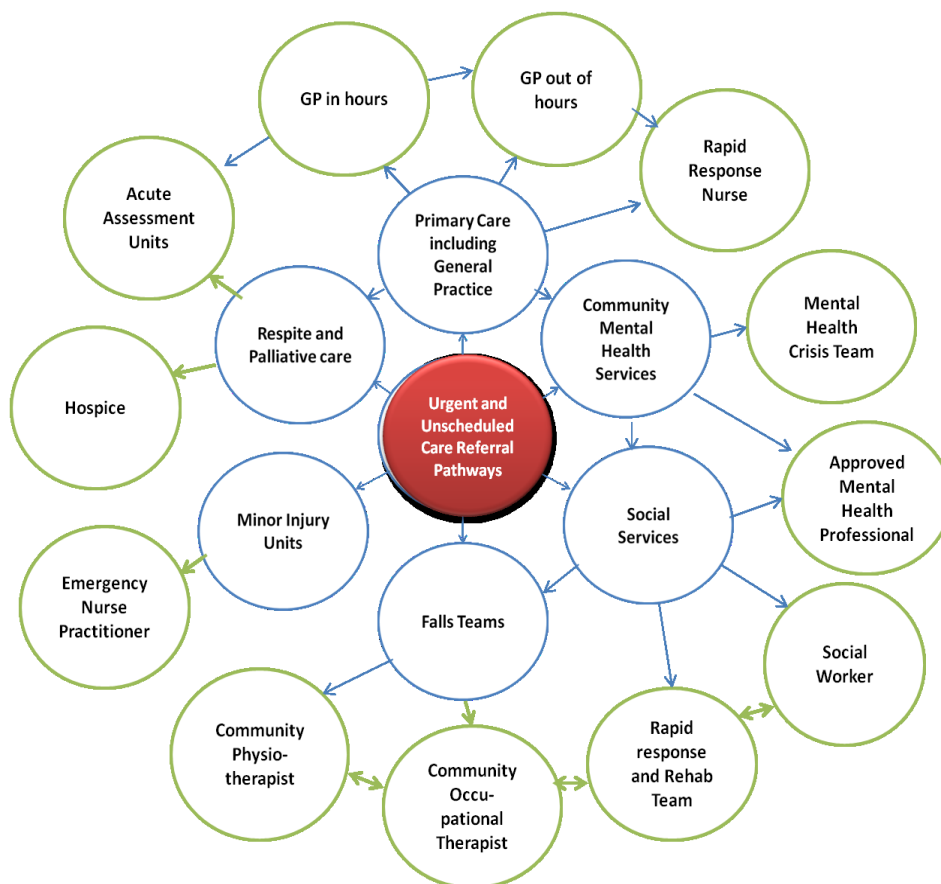
### QUESTIONS

1. Does Mary really need to go into hospital or is there potential for 'avoidable admission'?

2. If Mary is admitted to hospital, what might the consequences be?
3. What might John include in Mary's care plan if she is going to stay at home and who might be involved in this?

SPMs are able to provide a more enhanced assessment using the medical model for history taking and clinical examination and an increased range of tests, treatment options and care pathways (Figure 1). These include treatment for minor injuries and illness; care for exacerbations of chronic illness; and assessment of social-care needs, falls and mental-health risk.

As referral to other health and social care professionals is such an important component of SPM practice, interpersonal skills, including assertiveness, negotiation and persuasion are key competencies for the SPM.



**FIGURE 1: RANGE OF INTERPROFESSIONAL REFERRAL OPTIONS FOR THE SPECIALIST PARAMEDIC**

Case Study (continued)  
 Following assessment, John cleans Mary's head wound and uses a combination of wound glue and steri-strips to close the wound. John has

established that Mary has no clinical need to attend ED, but now needs to be assured that she is safe to remain at home. With Mary's permission, John contacts her daughter who comes to discuss further care requirements.

Having established that Mary tripped and fell but did not black-out and collapse, John then commences a falls risk screening, checking for any cognitive impairment or any difficulties in balance or gait that might increase Mary's risk of falling again.

John concludes that Mary's occasional difficulties with balance mean she is at risk of further falls and, following discussion with Mary and her daughter, he makes a referral to the local Falls Prevention and Management Service, a joint initiative run by Social Services and the local Primary Care Trust as part of a Rapid Response and Rehabilitation Team. John discusses Mary's case with team member Jill, a community occupational therapist (OT), who agrees to visit the following day; Mary's daughter says she will 'keep-an-eye on Mum' until then.

John advises them both how to keep the wound clean and when to remove the steri-strips. He then advises them what to do in case of any deterioration and documents a patient care record for forwarding to Mary's GP.

## QUESTIONS

1. How might Mary be feeling now?
2. What concerns might Mary's daughter have?
3. How important is it to involve Mary and her daughter in decisions about the best care pathway?
4. Try to find out what community health and social care teams operate in your area.

The outcome for people who fall is better if they receive personalised care at home, rather than transfer to hospital (Skelton 2006). Appropriate referral is important, as beyond the obvious and significant impact of injury, the effect of increased risk of further falls, loss of confidence, fear of falling, restricted physical and social activity, has significant implications, not only to the individual, but also to society in general. Consequently it is important that appropriate engagement of primary and community care services occurs for service users who are not transported to hospital. A full assessment by a

SPM should avoid the service user undergoing multiple assessments in different settings or by different health professionals (DH 2009).

#### Case Study (Conclusion)

The community OT and a colleague, visited Mary at home the following day. They were able to complete a multifactorial falls assessment, involving a more intensive assessment than the screening process and were able to identify specific, modifiable risk factors.

The assessment showed that Mary was at increased risk due to reduced mobility caused by her osteo-arthritis and a number of hazards in the home. A care plan was established and over the ensuing weeks, grab rails at strategic points around the house were installed, along with a toilet frame and shower stool. A community physiotherapist, visited twice a week to do progressive balance and limb strengthening exercises to help improve Mary's mobility and to get her used to using a wheeled walking frame.

Mary's daughter arranged for her to have a mobile alarm, simple pendant worn around the neck which connects to a dedicated call centre that can be activated if she falls.

It is now over 6 months since Mary fell and she continues to live independently with her cat and her daughter 'popping in'. She has not fallen again since. Mary said of her experience: "That night I fell, I thought, this is it! I was really worried that I might have to go into a nursing home. Who would have looked after my cat? John was so kind and reassuring that day. Everyone, who has helped me since has been the same. I can walk in my own garden and know that if I do fall again, someone like John will come quickly to help me."

#### QUESTIONS

1. How might things have turned out differently if Mary had gone into hospital?
2. How important were interpersonal skills in this case?
3. Do you think this interprofessional approach is a cost effective solution to the problem of falls?

In this case, the SPM was able to complete a comprehensive assessment, resulting in treatment and referral on to another community provider avoiding unnecessary hospital attendance and admission.

The Government's National Director for Emergency Access has stated: "The challenges for organisations in the provision of urgent care continue to be high profile and this care will no longer be provided just in emergency departments, or in General Practitioners surgeries" (SFH, 2007: pg.9). Whilst the SPM may be seen as an ideal solution for service users with urgent care needs, it has been recognised that services are still less than ideal. The NAO

(2011) identified that effectiveness relies on the availability of other services. Commissioners of such services are at different stages of developing electronic directories of services which can be used by practitioners to identify appropriate care pathways for service users. The SPM provides a rapid-response for service users in need of emergency or urgent care, that is service user-focused, in the least intensive and most convenient and appropriate place for the service user; *their own home*. The development of this new role has been in response to a wider recognition that people accessing care via 999 calls, do not all require hospital attendance.

In conclusion, it is perhaps best to view the SPM not only as a new role, but as an extension of an existing one. The key to the role's success is interprofessional working. Pollard et al define interprofessional working to mean, 'the process whereby members of different professions and/or agencies work together to provide integrated health and/or social care for the benefit of service users' (2005:10).

#### Approved Mental Health Professional (AMPH)

In some instances changes to legislation herald changes that impact on roles and can remove restrictions that limit duties and powers to particular professional groups. An example of this can be seen in the 2007 amendments to the England and Wales Mental Health Act 1983 (2007) (MHA). The amendments included important changes to the professionals eligible to perform various duties governed by this legislation, potentially having implications for interprofessional working and for service users and carers.

The main focus of this section of the chapter relates to the new role of the 'Approved Mental Health Professional' (AMHP) which replaced the previous role of the Approved Social Worker (ASW). Changes relating to the previous role of the Responsible Medical Officer (now called the Responsible Clinician) were also significant in terms of expanding roles. These roles are commonly seen in the context of a MHA assessment. This is where a service user presents with risks to their own or others' health and safety and a decision whether or not to detain them needs to be made, as there are no other



options. The assessment is typically undertaken by an AMHP, accompanied by the service user's Responsible Clinician and another doctor who is approved under the MHA or knows the patient well. It is not possible to discuss all the complexities of 1983 MHA and the amendments, but further details can be found in Brown (2010).

The role of the ASW, under the original 1983 MHA, could only be undertaken by qualified registered social workers. This role was replaced by the AMHP giving rise to a new dawn whereby Registered Nurses, Occupational Therapists, Chartered Psychologists and existing ASW's could potentially undertake, what Bogg suggests, is arguably the most 'powerful civilian role in the UK' (2008:115). The AMHP is responsible for deciding whether a MHA assessment is appropriate, co-ordinating all resources and aspects of the assessment and is key to the process of independently deciding if someone should be detained in hospital against their will. The Nearest Relative (Sec 26 MHA), a role not covered in this chapter, also has the power to detain their relative, providing they have two medical recommendations (See Hewitt 2009 for more information).

The creation of the AMHP role appeared to be an attempt to address several factors. Firstly concerns raised by the Association of Directors of Social Services relating to an ageing and retiring social work workforce and poor recruitment to the ASW role in some local authorities (Jones et al 2006, Bailey 2012). Secondly the desire to utilise the professionals within mental health teams differently by improving the skill mix and challenging powerful orthodoxies. A series of consultations with service users and carers revealed the necessity for new ways of working in mental health (CISP/NIMHE 2007a and b, DH 2007) and the Mental Health Alliance (2007) put pressure on government for improved mental health services which reflected service user and carer need. Arising from this work the notion of Capable Teams was developed with widening roles, to include functions under the MHA, and increasing flexibility, effectiveness and competence.

### Criteria, Training and Competencies

Although the eligibility to be an AMHP has been widened to other health professionals, the regulations (HMSO 2008) are clear that it remains the local authorities' responsibility to be satisfied that a person undertaking the role is competent in working with people with mental disorder. The local authority is the responsible body for commissioning regional AMHP training that is approved by the Health and Care Professionals Council (HCPC). This specialist training focuses on the values, knowledge and skills required to be competent and capable to undertake the role (GSCC 2010).

An eligible professional can apply to the local authority to undertake AMHP training. Prospective AMPHs need to have reached the appropriate level of professional competence in their own profession and have an understanding of the AMPH value base. If an applicant is successful they will be trained through a six month postgraduate programme where they will need to demonstrate legal knowledge, academic competence and be assessed in practice (NIHME 2007). Once warranted to practice, an AMHP is required to complete 18 hours of approved local authority training a year. All AMPHs register with the HCPC and adhere to their code of practice.

Writers such as Bogg (2008), Bailey (2012) and Laing (2012) express concerns that non-social work AMHPs may not come with social justice principles already established in their practice as the emphasis on this in their initial training is not as strong as is required for social workers (TOPPS England 2005, College of Social Work 2012). Hammick et al argue that there are 'similarities and differences in the professional values and ethical frameworks that practitioners in different professions work to' (2009:26). However, the need for all mental health professionals to demonstrate a working knowledge of equalities and social justice issues has been expected since 2004 with the development of 'The Ten Essential Shared Capabilities for Mental Health Practice' (Hope 2004:3) and endorsed by NIHME (2007).

The AMHP needs to demonstrate knowledge of social perspectives of mental disorder as noted in the NIMHE (2007) guidance. It could be argued that

maintaining a social perspective can be challenging to health professionals who may be more familiar with the 'medicalization' (Pollard 2010) of mental disorder. They may also have been professionally socialised into recognising the doctor as the lead clinician to whom they are subordinate. Golightley (2011) and Bailey (2012) argue that retaining the independence of the AMHP role is not only a legal necessity (Section 13(2) MHA) but also vital if the AMHP is to effectively challenge the medical perspective of mental disorder as the pathology of the individual. An eligible professional acquiring the new skills to be an AMHP may first need to make what Miers (2010) describes as the internal adjustment necessary for acquiring new skills and values and may find what Oliver and Keeping (2010) describe as their professional identity being 'in a state of flux'. Therefore the need to explore these aspects is recognised in the AMHP training.

An effective assessing team must endeavour to undertake a holistic assessment. To do this the AMHP needs to be skilled in interviewing, speaking with relatives and carers, gathering and scrutinising available information, balancing confidentiality and risk whilst working in collaboration with other agencies. This will enable the AMHP to make the most proportionate and least restrictive decision they can to mitigate the presenting risk and needs of the service users as explored by O'Gara (2008).

In the decision making process it is imperative for the AMHP to understand the legal framework for their practice and the powers they are eligible to deploy. Knowledge of the MHA (2007) and the corresponding Code of Practice (DH 2008) whilst essential is not sufficient, the AMHP also needs to understand the duties conferred on them under the wider adult and child legislation by which they are bound (NIHME 2007). Jones et al (2006) and Bailey (2012) reinforce those concerns highlighting the amount of legal knowledge that previous ASWs had to demonstrate in order to maintain their warrant. An informed understanding of how the Human Rights Act 1998 (HRA) influences decision making is also vital so ensuring that this level of legal training is present in the AMHP training for new non-social work AMHPs is essential. Writers such as Bogg (2008) see the additional HRA training

gained as one amongst many positive outcomes of non-social work AMPHs undertaking this role, as potentially this understanding will filter into their everyday practice. Furthermore Jones et al suggest that "...the AMHP being drawn from nursing and other professionals may add to the diversity and quality of the approved role" (2006)

### Structural and Organisational Issues

At the time of writing the AMHP role has existed for nearly 5 years. The majority of the existing ASW workforce converted to this new identity but despite the government's desire to see non-social work AMHPs in practice, estimates by the College of Social Work suggest that up until 2011 only around 121 were in practice nationally, compared with around 5,000 social work AMHPs (Bogg 2011). This may be due to a number of factors including structural and organisational issues, and the responsibilities of those who employ and approve AMHPs (NIHME 2007:3). The local authority retained its responsibility to approve, warrant and ensure there are sufficient numbers of AMHPs, these functions cannot be delegated to anyone else, including an NHS organisation (NIHME 2007:7). However, AMPHs do not necessarily have to be employed directly by the local authority, they can work for the NHS, voluntary or private sector organisations. This raises the question as to why, an NHS body or other organisation would wish to budget for their staff to train and undertake the work given that the provision of the AMPH service remains the local authority's responsibility. In practice this means that AMPHs can find themselves in a complex contractual situation as the local authority is responsible for their work as an AMHP, even though they may be substantially employed elsewhere. This arrangement appears to require the AMHP to have a dual contract between the employing organisation and the local authority.

For Social Workers working within mental health services, becoming an ASW/AMHP, was and is, an expectation of their continuing professional development linked to pay and career development. Given the limited numbers of non-social work AMPHs this aspiration does not yet appear to be

the case for other professional groups. This could be because they are not aware that they are eligible, combined with a lack of support or encouragement from their employer or, as suggested by Laing (2012), concerns in relation to the power and authority invested in the role. Also, in comparison to social workers, health professionals have negotiated more favourable pay and conditions. The lack of pay parity is likely to create tensions if remuneration for undertaking exactly the same role are not comparable (Jones et al 2006, Jackson 2009). Therefore, the expectation that the AMHP role could widen the career pathways for non-social workers seems to still be progressing. The limited take up from non-social workers illustrates that changes in legislation are not enough to change the workforce – more is needed in terms of awareness raising, support systems and incentives as well as reducing organisational boundaries.

### **Scenario**

A Community Psychiatric Nurse (CPN) in the local NHS Crisis Team has contacted the Adult Community Care Duty Desk to speak to an AMHP. The CPN wishes to make a referral for Mrs Stanton to be assessed under the MHA 2007.

Mrs Stanton's mental health is deteriorating and the CPN does not think it is safe for her to remain in the community as her mental illness is creating a risk to her own health and safety and that of others. She is calling from her car as Mrs Stanton had told the CPN to leave the house.

Mrs Stanton is a single parent to her daughter of 13 years who is currently in school but will be home within the hour. She is also the primary carer for her own mother who has dementia. Mrs Stanton had previously expressed concern as to who would look after her dog if she needed to go into hospital.

### **Questions**

- What knowledge do you think that the AMHP needs to hold to intervene in this situation?
- What legislation is relevant to this situation?
- What difficulties do you think might arise due to the number of professionals who are involved in this situation?
- What differing perspectives do the multi-professional team bring to this situation?

### **Activity**

If you were subject to a MHA assessment what attributes, skills and competencies would you want the professionals involved in your assessment and care, to hold?

Do you think any of these are restricted to a particular profession?

### Conclusion

In their discussion of professional boundaries Nancarrow and Borthwick's (2005) make the point that the roles and boundaries of professionals have always changed and developed and the two examples in this chapter reflect their view. Nancarrow and Borthwick provide a useful conceptual framework for considering types of changes identifying substitution, diversification, horizontal and vertical substitution (ibid 2005). In the case of the extension of the AMPH role one of the drivers for change was the shortage of social workers so can be seen as a horizontal substitution, as those taking on the role are expected to be qualified and experienced practitioners who, irrespective of their professional background, undertake additional training to equip them for their role. However, the SPM role can be seen as an example more of diversification as it is an extension to the task of just conveying a person safely to a hospital involving both treatment and care planning in situ. The SPM is now able to prescribe and use drugs that previously could only be administered by a medical professional so this could also be interpreted as vertical substitution.

Change and expansion of roles and boundaries are inevitable and happen all the time. Miers (2010) discusses development of professions and territories and how these adjust and change, Glasby and Dickinson (2008) consider how policy and organisational changes promoting partnership create changes that impact on individual roles and responsibilities and question the extent to which change leads to better outcomes for users. One thing all professionals can be sure of is that change is inevitable so as Hammick et al (2009) and Thomas (last chapter) argue practitioners need to contribute to development of services be prepared for change.

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