

NURSE AMHPs: AN EXPLORATORY STUDY OF THEIR EXPERIENCES

Abstract

Purpose

Mental health and learning disability nurses have been eligible to become Approved Mental Health Professionals (AMHP) since 2008 when the Mental Health Act 2007 was implemented. Despite this there have been proportionally low numbers of these nurses pursuing the AMHP role. The purpose of this study is to explore the experiences of these nurse AMHPs of training and practice.

Design/methodology/approach

Ten practicing nurse AMHPs were recruited from across four local authority sites. Using semi-structured interviews participants were asked to discuss their experiences of being an AMHP.

Findings

The participants highlighted the need to navigate personal, cultural and structural factors relating to accessing and applying for the training, difficulties with agreeing contracts terms, gaining comparative pay and undertaking the role.

Research limitations/implications

The limitations of this study are the small number of participants, and therefore the generalisability of the findings. Also respondents were practising AMHPs rather than nurses who considered the role but then rejected it as a career option.

Practical implications

This study has led to a gain a greater understanding of the experiences of nurse AMHPs.

Social implications

The results from this study will assist employing local authorities and NHS consider the barriers to mental health and learning disability nurses becoming AMHPs.

Originality/value

The value of this study is in the insight that provides of the experiences of nurse AMHP from applying to training through to being a practising AMHP.

Key words: Decision, AMHP, ASW, Admission, Risk, MHA, Detained, Nurse.

Introduction

This article seeks to explore the experiences of mental health and learning disability nurses (thereafter 'nurses') that have trained and practised as Approved Mental Health Professionals (AMHPs). Since 2008 nurses, social workers, occupational therapists and psychologists have been able to train through a regulated programme of study to become an AMHP once approved by a local authority. This opportunity was realised through the implementation of the Mental Health Act (MHA) 2007, which amended the earlier 1983 MHA repealing the previous role of the Approved Social Worker (ASW) and extending approved work to other eligible professionals. Most ASWs transitioned overnight to the new AMHP role with the benefit of some brief conversion training. However, this does not explain why we have not seen nurses becoming more visible in the AMHP role and in greater numbers (ADASS 2018). This paper seeks to explore why more nurse AMHPs are not more proportionally represented in the workforce given that 10 years have now passed since statutes made it possible for nurses to train and practice as AMHPs.

Nursing and the Emergence of the AMHP Role

The inclusion of other eligible professionals who can be AMHPs has not resolved concerns about the shortage of ASWs prior to the 2007 Act (ADASS 2006; Campbell 2010) as the numbers of nurses coming forward to train has not been significant (ADASS 2018). Social workers dominate the AMHP workforce, despite the profession's early fears that the opposite would happen as a result of a nursing influx into the new role (Campbell 2010, Bailey & Liyanage 2012, Bailey 2012). Speculation that nurses would take up the AMHP role without hesitation (Rapaport 2006) proved to be unfounded. On one level this could be seen as surprising as the AMHP role could have been seen as a new workforce opportunity that would be welcomed by health professionals as an autonomous step away from medicine, in the same way as social work saw specialist mental health roles as conferring additional prestige (Coffey

& Hannigan 2013). Equally, it might have been expected that the new AMHP role could be a bridge between physical and mental health (Hardy & Thomas 2012), by building what has come to be known as a 'parity of esteem' along the lines promoted by both 'No Health without Mental Health' (DoH 2011), and the recent report by the Mental Health Taskforce (2016).

The literature is relatively thin on any explanation as to why so few nurses have taken up the AMHP role. Perceived tensions about a damage to therapeutic relationship with individual clients have been raised if nurses, occupational therapists and psychologists undertake AMHP duties (Holmes 2002, Knott and Bannigan 2013, Coffey & Hannigan 2013, Hurley and Linsley 2006). However, there is some evidence from both social work (Coffey & Hannigan 2013), and nursing (Coffey & Hannigan 2013, Ashmore 2010) that it is possible to maintain a therapeutic relationship and execute a statutory role, even though it can be challenging (Bowers, Clark and Callaghan 2003, Hurley and Linsley 2006). Lastly, the requirement in some instances eligible professionals to first undertake a specific academic mental health module as preparation for starting the AMHP training has been identified as a possible barrier, or disincentive, to non-social workers (Knott & Bannigan (2013). This may be because the requirement to complete this module is seen as part of the continuing professional development (CPD) for social workers, and therefore the requirement to undertake this module does not translate well to CPD education pathways for allied health professionals. In addition, the association of gaining academic credit prior to beginning an academic programme of study may also not be as familiar to allied health professionals CPD as it is for social work CPD, as allied health professionals may be more familiar with clinical CPD models, which are non-credit bearing.

Local authorities are required by the Department for Health to employ what is deemed a 'sufficient' workforce of AMHPs to undertake MHA work. However, there is no reliable formula to establish how many AMHPs a local authority should employ (Huxley & Evans et al 2005),

and there is no guidance on whether professional diversity is important. Equally, a national profile of the number of AMHPs is lacking as there is no formal centralised database within England and Wales to record these figures, and no mechanism or requirement for these figures to be reported by the local authorities who employ AMHPs, despite holding these records themselves. This lack of a centralised workforce picture has recently tentatively acknowledged in a consultation document relating to the creation of 'Social Work England' (DoE 2018), the new regulator for the social work profession. Their proposal is to give recognition of post qualifying specialisms such as AMHP by annotating the new social work register, and is likely to become a regulatory power for Social Work England. However, how this will be utilised for non-social work AMHPs remains unclear.

The aim of this paper is to explore the experiences of nurses who have put themselves forward for AMHP training, and taken up this important professional development opportunity as an AMHP.

Methods

Research sample

This study employed a qualitative methodology with semi-structured interviews conducted with 10 nurse AMHPs focusing upon their recruitment, training, warranting and practice as an AMHP. This was part of a larger qualitative study comparing the decision making of social work and nurse AMHPs (Stone 2018).

Participants were recruited using non-probability sampling (Gilbert 2008) across four local authority sites. These sites were approached using information provided by the AMHP Leads Network (Bogg 2011) as possibly employing nurse AMHPs within their workforce. The AMHP lead for the local authority in these areas acted as introducer to the research study. The

interviews were transcribed, analysed and coded using NVIVO 10 software to enable themes to emerge (Braun & Clarke 2006).

The nurse AMHP participant sample included 3 men and 7 women. All started practising as an AMHP within 5 years of the legislative changes in 2007. The age range of the participants was, 30-39 (1 nurse), 40-49 (7 nurses), 50-59 (2 nurses). Ethnicity of the participants was not captured. All the participants were interviewed face to face, using a semi structured interview schedule of questions.

Ethics

Ethical approval for the research was given by the authors' university, which also acted as the research sponsor. As NHS employment structures pertaining to where nurses work in their substantive roles can differ from local authority employment structures for their practice as an AMHP, the ethical governance requirements differed for each site. Ethical approval was gained from either local government research governance and/or through NHS Research and Development departments depending on local requirements and was dependent upon whether the local authority and NHS mental health services were integrated. This ultimately led to complexity in gaining ethical approval for AMHP focused research (Stone et al., forthcoming) as there is no clear process. Valid consent was gained from each participant.

Findings

The themes arising from the 10 participants suggest a range of factors that have been navigated by participants through applying to become an AMHP, undertaking the training and moving into actual practice. The data below has been set-out following this procedural experience. Four participants' highlighted difficulties moving through the process of gaining the training to eventually gaining approval, one participant stated:

It took a long time, well, first of all from being accepted on the course to then getting the funding agreed, because the local authority was saying, "Why should we pay?" and the trust was then, "Well, why should we pay?" So that became a sticking point, but eventually it got resolved (Participant 4).

In this scenario it was not gaining a place which was challenging but resolving who should take responsibility for funding the training.

Three participants discussed the AMHP education they received. One participant stated that:

I just really enjoyed looking at something from a different perspective as well, especially having worked in this profession for so long. It's interesting because all the social perspective which all the social workers knew, I think the nurses struggled more with that than on the course. Because it's like it's not obvious to us, the more social things, because the course, certainly when I did it, was still very much for social workers, and so some of the bits that we did know, like the medical stuff, I think the social workers didn't know, But actually, the things that they thought was a given that people would know, we didn't know because we're not social workers. So that's been really interesting. That aspect of it, and obviously the law is for everybody, but yes, so that was the steep learning curve, the social perspective side of it, but really interesting, really interesting. (Participant 4)

This participant valued learning about the social perspective and its application to certain areas of mental health practice. They appear to be locating that knowledge within social work practice as being a different professional culture to their own. They go on to illustrate this by stating that the social perspective is not familiar to nursing, and assumptions were made on the programme that nurses would be familiar with the social perspective in mental health.

Another participant reflected:

I've been a nurse since the 1980s, so it's been quite a while. So I really enjoyed the training. I enjoyed the social work, the culture, the approach to understanding depression and issues like race and stuff like that. And I thought that was really good. In a way it's sad that we didn't have that all those years ago. I think it's really good that that's how it is. But also, I suspect that social workers probably did have stuff like that, that we didn't. So I think that was brilliant. It was very liberating. I enjoyed the course tremendously. It did feel like you were going into slightly alien territory. Most of the nurse AMHPs had left. (Participant 9)

For this participant the experience was positive and they enjoyed the training despite it being professionally and culturally different. They appeared to benefit from gaining additional knowledge but seemingly identifying with it as "going into alien territory" of social work but still recognising the benefits it could have on their own practice.

Three of the nurses highlighted more directly the different knowledge bases that either they brought as nurses or that social workers contributed. One participant stated:

I think as a nurse, you bring a lot of knowledge, a lot of expertise around [mental health] - We think about alternative approaches to managing mental health, other than medication ... Also, I do think we have a very good grounding and basic understanding in mental health and risk and risk management. (Participant 6)

This participant suggest that nurses can bring a broad range of skills, independence and knowledge discernment to the AMHP role, seemingly wanting to challenge the perception that nurses come from a purely pharmacological discourse. However, another participant gave a rather different perspective:

One of the things why I wanted to become a nurse AMHP was my background, my medication knowledge. Medication has been helpful for - certainly if you go out with

people from other backgrounds, or other disciplines and learning disabilities or older people sometimes and the way medications can affect the way somebody presents, because I've seen these things before. (Participant 7)

For this participant the pharmacological knowledge is an important knowledge contribution that she would bring to the role and hence a strength which justifies their decision to train as an AMHP. One participant highlighted the need to familiarise themselves with some of the social work knowledge for the AMHP role as well:

The fact that childcare, paying for childminders, all that stuff, that makes me a bit different from my social work colleagues ... (Participant 1)

This participant is acknowledging that some knowledge required to be an effective AMHP was previously unfamiliar to them. Although not seen as insurmountable by this individual it does highlight differences between nurses and social workers that can exist at the start of training.

For two participants the biggest challenges to becoming a practising AMHP rested with gaining approval to practice and gaining the AMHP warrant following their training as illustrated by the following two quotes:

Gaining approval to practice as an AMHP and ultimately gain their warrant to practice. It took a long time for the first batch to get warranted because there was an argument about who was going to pay our insurance. (Participant 2)

I think when we went to panel, we were given a bit of a harder time, and it was a bit more of a struggle to get through to get warranted. This is my opinion. (Participant 6)

The participant's responses highlighted their surprise at the structural challenges they experienced to transitioning to practicing AMHPs, such as who was going to insure them, and their perception of it being harder than expected to gain a warrant.

Another participant highlights that it has now given them greater ability to contribute to the team:

I'm always an AMHP because people will come in and ask for advice or phone or I will go out and do assessments, sorry, just general assessments but where they think, "Actually, this looks like it might turn into a Mental Health Act assessment, let's send [participant named], " because I'll be able to do it.. (Participant 1)

This participant is making the clear distinction between a mental health assessment and a Mental Health Act assessment. The former is seen as indicating the state of a person's mental health, and the latter the need for an assessment to determine if a person should be detained in Hospital. Although being an AMHP had given him a beneficial function within his team, he is experiencing being asked to undertake mental health assessments, which might be closely followed by a Mental Health Act assessment. Other participants commented that:

In fact, what you often do find is that anything medical comes up and they shout across the room, "Hey, you'll know this, you're a nurse," kind of thing...Or occasionally, certainly ones on medical wards here, or any of the acute hospices, they say, "Maybe you should go up to your nurse, she'll understand what they're talking about," like the medical issues... I've found the same, people are saying, "Who's this nurse that's going on the AMHP course again?" Then when you say who it is, they go, "Oh, yes, he's all right, that's fine." (Participant 4)

In this scenario, the medical skills of a specific AMHP appear to be being sought out based upon the specific needs identified within the MHA assessment. In other words it is their experience that if an assessment is needed on an acute medical ward or hospice they are considered first for the assessment because of their nursing background. This was echoed by another participant who asks themselves:

Is this going to turn into a Mental Health Act assessment? I would have done it – there's confusion about this in the organisation. It doesn't matter to me whether I'm doing a general assessment or a Mental Health Act assessment. If somebody says to me, "Do this. Please go work at that," I'll do it as long as I have time to do it. I'm happy – I'll do what I'm told, to a certain extent. I can see it is good practice that if I met somebody then perhaps I could do it, but that's not clear within the organisation.

(Participant 1)

In this sense the participant is stating that they are happy to be directed to undertake assessments, but suggests that this role change needs direction from the organisation when undertaking their clinical as being a nurse is influencing their AMHP work.

For some of the participants a potential conflict of interest seemed to exist in relation to this issue. One such participant explained:

I'm always very conscious that, if I've seen the patient in the morning, as liaison, then I wouldn't do a Mental Health Act Assessment. Because I couldn't go in the morning, say, "Hi, I'm from the liaison team", then in the afternoon, "Oh, hi, do you remember me from this morning? Well I'm not that person any more, I'm this person." So you've got to have that degree of independence. (Participant 5)

In this circumstance, the nurse is recognising the need for clarity and independence when switching between roles when seeing the same patient in the same clinical context but from differing professional roles. Similarly another participant highlight how difficulties can arise if the nurse AMHP works on the ward:

Also, that worries me with AMHP assessments as well. Then getting in touch with [council named] and asking them and saying to them, "I think there is going to be an issue if I do Mental Health Act assessments, and then they come to the ward and I go

out and assess them as an AMHP. Then they came back to the ward and then I'm a nurse." I don't think that's right' (Participant 10)

This participant is considering how to balance differing roles when they both admit patients to a ward as AMHP but also work on the same ward. They are doubtful if the local authority will understand this potential conflict of interest.

The requirement to maintain independence was raised by five participants in relation to their primary professional role as a nurse and their relationship with medicine. One participant stated:

I think there's a misconception that nurses are all about the medical model. We're not. We've got brains and everything... I think the AMHP manager has fed back to the head of nursing that she's really - there were concerns about nurses or social workers being AMHPs, but her experience of us is that we're really hard working. We're not frightened to take a doctor on. I think the idea is that we'd be like a little bit, "Carry on, doctor," and just giggle, and go, "Whatever you say, doctor." But I think they realise that we're quite strong minded individuals that, as much as anybody, have got a real sense of what our role is within an autonomous role; that we're there to look at the least restrictive option, and that we have as much of a knowledge and mature attitude towards thinking about the patient holistically, as a social worker, and thinking about what's the best for the patient, and not just always signing papers. But your research will probably prove that in one way or another. (Participant 6)

For this participant there is recognition that, as AMHPs, nurses can and do practice beyond medical discourses and approaches to mental health, as well as being able to challenge dominant pharmacological approaches. This view was echoed by another participant who was aware of concerns about nurses becoming AMHPs:

I think certainly one of the things locally that was concerning for social workers probably ... was that, "Are nurses too affiliated with the medical profession and they'll just go along with whatever the doctor says?" I think very quickly people realise that that's actually not the case and actually nurses argue with doctors all of the time on a day-to-day basis... because nurses are used to assessing people's mental states as well, so the whole idea of them, certainly in liaison as part of our job is to do full assessments of patients and their mental states, so we already have an idea about that. Which obviously is not the AMHP's role, so that thing's quite interesting. But in terms of not going along with the doctors, I think it's certainly likely, very much proved that we don't. Because that certainly was said to be a bit of a, you know, nurses are just doctors' handmaidens and should do whatever the doctor says. I think they've realised that that certainly isn't the case (Participant 4).

This participant is arguing that nurses are in a good position to debate with doctors about what approach should be taken following an assessment, due to their own skills and knowledge as a nurse.

Another important dimension to independence issues concerned independence from employers.

One participant highlighted where this had become of concern for them:

I had a phone call from the service development manager for the [name] team saying, "Why haven't you got a different doctor? Why haven't you asked this doctor to come earlier?" I said, "I can't. This is the way I've done it." He said, "Are you aware that this person is going to breach?" I said, "I'm here as an AMHP now." He said, "Well, you work for the [name] team, so you have to have that awareness," because apparently the breach it costs them something like £50,000 or something ridiculous like that. Breach times are very serious. I was told people get sacked over breach times, so I had that as well. Then I had to try and explain to my immediate manager that if you're

asking me to come over as an AMHP and you want me to do this, you can't put pressure on me to be worried about breach times when I think I need to get an appropriate doctor, because I've got to justify on those papers why I haven't used the doctor that has had previous acquaintance. He said "Well, you still work for [name team]." I was coming across a lot...I was thinking, "Oh, God. I wish I was a social worker, because I wouldn't have these problems." As an AMHP social worker, you get the call, you go in and then you come back out, whereas because I'm in the Trust, I'm having all this stuff going on. (Participant 10)

In this scenario the participant is highlighting that the trust management appeared to not understand who the participant was working for when undertaking AMHP work and the relevant legalities for the participant when deciding which doctors to use.

Nine of the participants discussed issues relating to how well they integrated into the AMHP service as nurses, with five of these highlighting that integration was not challenging. For example, Participant 9 stressed that:

I think they would be slightly more worried if I used certain terms. They'd think, "Oh, he's straying back to his roots." But it didn't feel oppressive in any way. They were very keen. Both my boss and the boss of the AMHP thing were very keen for us to do it. Probably, there was a little bit more vigilance. They were slightly concerned that we would be too much in the pockets of doctors and stuff. But yes, fine, really. (Participant 9)

For this participant joining the AMHP service was positive with early discussions relating to independence helping to clarify his autonomy. For another two participants integrating into a social work dominated service was not as positive. One of these participant stated:

I think we're all pretty isolated. I think the nurses in particular in this trust are a little bit isolated but that's. By no other virtue than the fact that I'm a nurse, will be left – I mean I can tell you now I will not work as an AMHP that day because I think personally it would break my health and safety concerns, based on the fact that – ordinarily I'm isolated anyway ... I think there's a certain amount of, there can be at times, suspicion about whether or not we are part of that group. (Participant 1)

For another nurse they have found becoming an AMHP has broken down some previous professional divisions:

What they had always said was that because we were so generic and aware in Community teams, as was, really, the two differentiating factors for us were that we gave injections and the social workers did Mental Health Act Assessments. Obviously, we now give injections and do Mental Health Act Assessments. Obviously, if we are Care Coordinators and Care Managers under CPA, then we are all doing the same job. Some of the older social workers, interestingly, felt it a real threat. (Participant 2)

This participant is suggesting that the differentiating factors between professions have now gone, with only some feeling threatened by the change.

Some participants highlighted that they experienced difficulties with their terms and conditions of employment when they moved into AMHP practice. This relates to their contract, pay and recognition and how they gained approval by the local authority. One participant stated that in terms of his contract that:

I don't have a dual contract. I've got the same contract as I've ever had. (Participant 1)

For this participant they have seen no alteration in their terms and conditions of employment or recognition of the additional local authority responsibilities. Another participant commented that they are not certain why their trust agreed to train AMHPs:

I don't know why the Trust agreed to train some nurse AMHPs up because they don't really know what to do with us, or where to put us. (Participant 10)

Factors relating to pay and grading was highlighted by six of the participants whereby they either did not feel adequately remunerated either through grade or honorarium pay. One participant stated:

I qualified along with my colleague in the exact same team who happens to be a social worker. We both did our training at the same time. We both got warranted at the same time. Because she's a social worker she automatically got increments as an appreciation of her taking all this extra work and doing this extra ... Whereas as a nurse, in the age old tradition, you get a slap on the back, "That's great. That's wonderful". In the general sense there's a difference. If you're a social worker you get a pay rise, a general nurse you don't. I suppose that, just in the local situation, it grates a little bit if there's an expectation of I'm going to work beyond my terms and conditions of my job description. AMHP is not in my job description. (Participant 1)

This participant is able to make a direct comparison with a social worker in the same circumstances as them, and clearly feels they are not receiving the due recognition. Another participant added to this perspective:

The other thing is that we don't get paid. We don't get a penny for our responsibilities. Not an additional penny. We had to be Band 7s to apply to go on the training. The money that you get as a Band 7 is equivalent to what you would get at the time as a social worker with your additional increments. It is not part of our contract, not that it

is part of the contract for the social workers in [town stated]. There is no monetary gain. I think the people who did it were very experienced Mental Health workers, and were just really interested in the work and saw it as a very important part of our work with clients (Participant 2).

For this participant they are not only dissatisfied with the lack of remuneration but also fact that they needed to be a band 7 before they could even apply for AMHP training and the implications thereafter for any additional increment after becoming an AMHP.

Discussion

The aim of this paper was to explore the experiences of nurses who have been able to successfully train and practice as an AMHP. The findings from this exploratory study suggest that the participants of this study have been required to navigate personal, cultural and structural factors during the transition from being a nurse to a nurse AMHP, which are congruent with Neil Thompsons PCS model (Thompson 1997). Structural factors are explicitly highlighted as far greater by participants than personal and cultural factors, although often they overlap.

When considering the personal factors that participants experienced there is clear indication that they enjoyed the training, benefited from the educational opportunity and been motivated to progress. Issues relating to the maintenance of a therapeutic relationships with service users whilst undertaking AMHP work was not highlighted, despite being raised as a factor in the earlier literature. However, the participants did highlight personal dilemma's and instances where potential conflicts of interest were recognised as they work across frontiers between their regular employment and their AMHP duties.

Participants acknowledged the cultural difference and issues that they experienced in their training and eventual practice. Participants articulated that they can bring additional

knowledge bases to a traditional AMHP team, such as pharmacology, and drawing upon their nursing training more generally which would otherwise be absent from the AMHP workforce. This may be welcomed by service users and carers given the differing discourses that can be applied to understanding and intervening when a person is experiencing mental disorder. Adding to the diversity of AMHP service was highlighted by some participants as a strength given the additional expertise that nursing can also bring. However, some participants raised concern about feeling isolated as a nurse AMHP, and this raises questions about how to integrate a diverse AMHP workforce. Bressington, Wells & Graham (2011) found in their study that AMHP training does bring harmonisation across professional backgrounds through the completion of AMHP training, however this might not be enough to overcome long-standing cultural divides where they exist.

Structurally, the findings suggest that participants found accessing and applying for the training, agreeing contracts terms, gaining comparative pay and undertaking role challenging. Local authorities across England and Wales do not have consistent national remuneration arrangements for social workers, compared with nurses under the NHS Agenda for Change (NHS Employers 2018). It is therefore unlikely that parity of pay can be achieved between nursing and social work when undertaking AMHP work without a national negotiation for social work as well which is comparable to Agenda for Change. To this end, it may offer a disincentive to nursing colleague to undertake AMHP work with no prospect of additional financial compensation, as social workers may be paid less. Although perhaps with the current governments intention to better integrate health and social care nationally, this issue may be seen as one that can be overcome through the green paper proposed for the summer of 2018.

A recent ADASS study (ADASS 2018) highlighted the different ways AMHP services are structured nationally. AMHP services are diverse across England and Wales from dedicated teams focused on mental health act work alone working 9-5 (with supported from Emergency

Duty Teams outside these hours) to 24 hour services working around the clock. To HUB models where AMHPs are called upon only when needed to undertake a mental health act assessment, leaving their substantive role for a time to undertaken that assessment. AMHP services can also be supported by sessional AMHPs working one day a period on a rota to be additionally called upon when needed.

The challenges faced by nursing AMHP working within these structures may differ according to their structure. For instance, nurses may find working for a local authority one day at a time or when called upon challenging; due to balancing their substantive NHS nursing duties as well if AMHP work cannot be contained within the duty day. In this scenario, commissioners would need to consider the implications of when AMHPs work needs to continue beyond the rotated time due to unavailability of psychiatric beds, difficulties in determining and consulting nearest relatives and court appearances for example. Nurse AMHPs will need to reflect on how working on a rota may influence their decision making as social work as had to do, but without the benefit of working for a single employer. It is likely that a more integrated approach between the NHS and local authorities to the delivery of mental health services may offer a solution to structural difficulties that have been experienced to some degree; however, the local authority still currently remains responsible for AMHP work regardless of which profession is undertaking it.

Overall, seeking to resolve these personal, cultural and structural factors may be brought about by seeking to understand the motivations of nurses, NHS and local authorities to train nurse AMHPs and support them to practice. These could be framed in this way, firstly why do nurses wish to gain the status of an AMHP. Secondly, why would an NHS Trust want to sponsor and support a nurse to train and eventually practice as an AMHP? Thirdly, why would a local authority want to approve a nurse to practice as an AMHP and support them in practice? Answering these questions may assist policy makers and commissioners to identify with the

factors that the participants have highlighted in this study and then identify what needs to be undertaken to overcome them.

None of the participants that took part in this study were AMHP leads or AMHP practice assessors. This raises an interesting point that if nurses have struggled to get off the starting blocks into AMHP practice, how they will become part of the AMHP leadership either nationally or locally. It needs to be considered whether the potential for a nurse, psychologists or occupational therapists to become an AMHP, has fallen into the same remit of law as the nearest relatives power to detain. The legal provision is there, but it is not often used.

Conclusion

Although the MHA is currently under review (DoHSC 2018) it is unlikely that the government will make a decision to reduce workforce capacity by returning the role to social workers alone. Therefore, developing career pathways for nurses to move into AMHP roles can only be made easier where the personal, cultural and structural difficulties that have been highlighted above are resolved. Although some participants were positive about their experiences, participants also highlighted the challenges that they had experienced negatively. The reasons for the experiences need to be explored by commissioners if they want to engage, train and supervise nurse AMHPs. An analysis of the motivational factors for developing a nurse AMHP workforce may assist in this, as well as showcasing examples national examples where nurses have smooth transitioned into AMHP practice. This offers some explanation as to perhaps why nurse AMHP numbers are disproportionately small compared social work, and gives an indication as to what may need to be achieved to make the navigation of structural factors easier for nurses, occupational therapists and psychologists to train and practice as AMHPs.

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